

7
THE MONTHLY

ABSTRACT OF MEDICAL SCIENCE:

A DIGEST

OF THE

PROGRESS OF MEDICINE AND THE COLLATERAL
SCIENCES;

BEING A

SUPPLEMENT TO THE MEDICAL NEWS AND LIBRARY.

VOL. I.

JULY TO DECEMBER, 1874.



PHILADELPHIA:
HENRY C. LEA.
1874.

PHILADELPHIA:
COLLINS, PRINTER,
705 Jayne Street.

SUPPLEMENT TO THE MEDICAL NEWS AND LIBRARY.

No. 384.

(For List of Contents see last page.)

December, 1874.

Anatomy and Physiology.

The Physiology of the Kidney.

M. CHARCOT, in a lecture on the Physiology of the Kidney (*Le Progrès Médical*, No. 36), refers to some experiments recently performed by M. Heidenhain, the result of which has been to confirm in a remarkable degree Bowman's well-known theory of the function of the Malpighian bodies and of the convoluted tubes respectively. Bowman believes that, while the Malpighian bodies are the main outlets for the watery part of the urinary secretion, the peculiar solids of the urine are secreted by the gland-cells which line the convoluted tubes. In opposition to this theory, Ludwig and others suppose that all the constituents of the urine are secreted in a very diluted state by the Malpighian bodies alone, while the function of the tubular portions of the kidney is to absorb the excess of water. It has always appeared to us that, while Bowman's theory is consistent with the anatomical facts, the theory of Ludwig is consistent neither with facts nor with physiological analogies. M. Heidenhain's experiments, as we have said, are confirmatory of Bowman's theory. The living kidney has a strong affinity for indigo; so that, when an alkaline solution of sulphate of indigo has been injected into the blood of a living animal, the urine and the kidneys quickly become tinged by the colouring matter. By varying the conditions of the experiment, M. Heidenhain found that he could determine the exact part of the glandular structure by which the colouring matter of the indigo was excreted.

The effect of dividing the spinal cord below the medulla oblongata, while artificial respiration is performed, is to cause complete suppression of urine; but sulphate of indigo, having been injected into the blood, is found to have given a blue tinge to the convoluted tubes, while the Malpighian bodies and the straight tubes remain untinged. The colouring matter of the indigo is found in those portions of the kidney which are believed to perform the true excretory function. But the analysis was carried further. If the animal were killed ten minutes after the injection of indigo into the blood, the colouring matter was found only in the cells of the convoluted tubes, while the clear canals within the tubes were free from colour; but, if an hour or more had elapsed before the death of the animal, the colour was found to have passed from the gland-cells into the canals of the tubes, where, in the absence of water to remove it, it formed a crystalline deposit.

M. Heidenhain performed other experiments with similar results. Thus the effect of ligaturing the ureter is to cause complete suppression of urine. If, after this result has been obtained, indigo be injected into the blood, the gland-cells of the convoluted tubes become tinged precisely as in the experiment before described. These experiments show that the secretion of the colouring matter by the kidney takes place when the watery secretion is suppressed; and this separation of the colouring matter is effected by the gland-cells which line the convoluted tubes. It is in the highest degree probable that the solids of the urine are secreted in like manner by the same cells. M. Heidenhain found that, after the injection into the blood of a concentrated solution of urate of soda, the salt was deposited in the form of yellow granules within the convoluted tubes, while the Malpighian bodies contained no trace of the deposit.

This result of injecting urate of soda is analogous to what is normally found in birds, whose urine is mainly composed of granules of urate of soda; and Von Wittich has observed that, while the granular salt may be found within the gland-cells of the convoluted tubes, the granules are never seen within the Malpighian bodies.

These experiments render it in the highest degree probable that, while the specific urinary constituents are secreted by the gland-cells which line the convoluted tubes, the Malpighian bodies pour out water to flush the tubes, and the straight tubes of the medullary portion of the kidney act as conduits for the urine which has been secreted in the cortical portion of the gland.—*British Medical Journal*, Sept. 19, 1874.

On Recurrent Sensibility.

MM. ARLOING and TRIPIER (*Gazette Hebdomadaire*, No. 36, 1874) publish the results of some new researches on recurrent sensibility, and suggest applications of those results to pathology and operative treatment. The authors had previously sought to interpret the fact of the persistence of sensibility in the integument of the human hand after section of the median, radial, and ulnar nerves, and had demonstrated the following points: the existence of recurrent sensibility in cutaneous nerves; the extension of the influence of sensory nerves of the skin beyond their zone of anatomical distribution, and that the persistence of sensibility in the peripheral extremity of the divided nerve, and the persistence of sensibility in the corresponding integument, are always associated phenomena. The exactitude of these data having been verified in the upper and lower extremities, the authors next proceeded to examine whether they were applicable to the nerves of the face. Analogous researches made on the chief branches of the trigeminal gave very variable results. They then commenced a series of experiments based upon the fact that the nerve-tubules are always found intact at the peripheral extremity when sensibility persists, and that, on the other hand, the tubules are degenerated when sensibility cannot be demonstrated. The researches were first made on the facial nerve of soliped animals, the peripheral extremity of which, according to M. Chauveau, is always found insensible, after section has been made below the parotid. Repeated experiments made by MM. Arloing and Tripier gave identical results, and on examination of the peripheral extremity all the nerve-tubules were found to be degenerated. In one case, where the section was made in front of the masseter muscle, compression of the peripheral extremity revealed doubtful sensibility; after a lapse of time, some intact fibres were found here. This result was due, the authors think, to the section having been made nearer the periphery. In order to prove whether this hypothesis was correct they instituted the following experiments. The inferior branch of the facial nerve of a mule having been exposed behind the labial commissure, the nerve was divided and its peripheral extremity isolated over an extent of two centimetres. At the end of two hours the peripheral extremity was again isolated, and when the nerve was more compressed the animal drew back its head and depressed forcibly the lower lip. Subsequent microscopical examination of hardened portions of the divided nerve showed about twelve intact nerve-tubules at the peripheral extremity, and about eight degenerated nerve-tubules at the central extremity. Experiments were next made on different branches of the trigeminal nerve in various animals. The authors assert that sensibility is very evident at the peripheral extremities of the supra-orbital and infra-orbital, and the mental nerves of the dog after division. It is less evident in the supra-orbital and infra-orbital branches of the horse and rabbit, but is well marked in the mental nerve of those animals, a fact due to the more considerable number of intact nervous tubules at the peripheral extremity of the last-mentioned nerve.

In applying those experimental data to pathology and operative treatment the authors lay down the following propositions. 1. It being admitted that all nerves possess recurrent nerve-tubules, it may be supposed that special morbid conditions resulting from this anatomical disposition will present themselves

equally in all nerves. Thus one may conceive the existence of neuralgiæ of the facial as of the trigeminal (the so-called functional neuralgiæ for example); 2. Since, speaking generally, the recurrent fibres are the more numerous, the nearer one approaches to the periphery where the anastomoses are more numerous, whilst, as one approaches the main trunks, the fibres diminish in number and finally disappear, there ought to be marked differences in the mode of action, and the manifestations of the morbid agent, according as it affects the trunks or the periphery. The nearer the morbid agent is placed to the periphery, the greater the intensity and diffusion in its mode of action, and in the manifestations to which it will give rise; and, on the other hand, the nearer the morbid agent to the trunk of the affected nerve, the less intense will be its mode of action and its manifestations. The authors hold with the majority of pathologists that, except in cases of compression, neuritis is very rare in neuralgia; they believe that it may arise from morbid changes in the proximal portions of nerves, but they do not think that it is absolutely necessary to admit these changes in any degree in order to explain the extension or diffusion of morbid phenomena, an exact notion of which may be formed by taking into account the peripheral anastomoses. The authors concluded that in the treatment of neuralgia the indications and operative proceedings ought to be much modified. Wishing to remain within the region of general considerations, they content themselves with these statements: 1. For motor-nerves or nerves supposed to be motor, the trunks in question ought not to be divided, but rather the neighbouring sensory branches which supply to the former recurrent nervous branches; 2. For sensori-motor or sensory nerves, it is necessary to find out whether the morbid agent affects the trunk or its branches. In the former case, simple neurotomy would suffice to interrupt the transmission of morbid impressions, whilst in the latter recourse should be taken to associated sections, made so as to interrupt the different modes of transmission, and at the same time cause the least possible disorder.—*Lond. Med. Record*, Oct. 21, 1874.

Materia Medica and Therapeutics.

On the Therapeutic Properties of Bromide of Camphor.

In the number of this Journal for September (page 103) we gave the results of Dr. BOURNEVILLE's physiological experiments with bromide of camphor; since then Dr. Bourneville has made his therapeutical experiment at the Saltpêtrière, under the direction of M. Charcot. The form of the drug administered was the same as that which has been employed up to the present time in all the hospitals of Paris—Dr. Clin's bromide of camphor dragées. In addition to the physical properties of bromide of camphor already mentioned, its characteristic odour and disagreeable flavour, it may be noted that it is insoluble in water, and changes when exposed to the air, so that the dragées are the best form in which to administer it. Each dragée contains exactly ten centigrammes ($1\frac{1}{2}$ grain) of the bromide of camphor, covered by a thin coat of sugar, which preserves the drug, masks both its odour and flavour, and renders it easy of deglutition. These dragées become rapidly disintegrated in the stomach. Among the cases already published we find the following:—

In one case, a woman aged sixty-two, suffering from heart disease attended by insomnia, twenty centigrammes only (two dragées) were efficacious. In the case of a woman aged forty-six, who was suffering from progressive locomotor ataxy, in whom insomnia alternated with disturbed sleep troubled by nightmares, it was necessary in order to obtain a decided improvement to administer eighty centigrammes (eight dragées). A woman aged forty-six, who for six years suffered from chorea, who had not been able to walk for a year, and was

tormented by such incessant and violent movements that they drew her out of her bed, and who was also unable to sleep, had administered to her as high a quantity as 120 centigrammes (twelve dragées). Her sleep became calmer, she remained quietly in her bed, could walk a little, and often remained fifteen or twenty minutes undisturbed by choreic movements.

Three women under the care of M. Charcot, of the respective ages of fifty, sixty, and sixty-seven, were attacked by paralysis agitans, and pronounced incurable. They took from twenty centigrammes to one gramme (three to fifteen grains) of bromide of camphor, daily, in quantities varying from one to ten dragées, in progressive doses. A marked amendment followed.

Bourneville (*Progrès Médical*) has submitted the efficacy of bromide of camphor to a severe test by choosing as a field for his experiments a hospital for incurables. If it succeeded in these obstinate cases, still greater was the probability that it would act beneficially where the conditions were more favourable, and the illnesses of more recent origin. A patient in the Hospital de la Pitié, twenty-four years of age, suffering from acute rheumatism, was attacked by chorea in the left arm. He was cured in five days. The dose was sixty centigrammes (nine grains) daily, given in six dragées.

In the same hospital, a woman, aged twenty-two, was attacked by violent hysterical chorea, with hysterical vomiting. The dose given was first forty, and then sixty centigrammes, daily. Her cure was rapid.

A young woman, a patient in the Necker Hospital, suffering from induration, with insufficiency of the mitral valve, showed symptoms of poisoning from the first day digitaline was administered to her. The digitaline was discontinued, and the bromide of camphor substituted. The heart-beats diminished in frequency and became regular. The medicine was relinquished, and the improvement obtained continued the same a fortnight later.

A man in the same hospital, presenting the same conditions, received equal relief.

A young woman, suffering from nocturnal incontinence of urine, had taken bromide of potassium during fifteen days without any amendment. Four dragées of the bromide of camphor cured this painful infirmity, at least for the time being. The patient is still under treatment.

A patient who was tormented by nervous cough, which entirely deprived her of sleep, took two dragées, night and morning, and the symptoms were abated in a few days.

At the Cochin Hospital a case of paralysis agitans was considerably calmed by a daily dose of four dragées. The patient was a woman, about forty years of age.

At the present time our knowledge of the physiological action of the bromide of camphor, and of its value as a therapeutic agent, is imperfect. It is, nevertheless, evident that the administration of this drug has been followed by incontestably beneficial results, which have been corroborated by observation in a number of the hospital wards. Bromide of camphor is a well-defined substance, having a characteristic crystallization, smell, and flavour; and a powerful sedative both to the nervous system and circulation, acting as a hypnotic and regulating innervation.

It would be premature to specify the precise dose which ought to be administered. In the generality of ordinary cases it has been given to adults in doses of from twenty centigrammes to one gramme, a dose two or three times during the morning, a dose before dinner or with it, and, finally, another before going to bed. The dose naturally varies according to the illness and the special symptoms presented.—*London Med. Record*, Oct. 7, 1874.

—

On the Action of Strychnia.

F. A. FALCK (Volkmann's *Sammlung Klinischer Vorträge*, No. 69) says that strychnia is absorbed and acts most quickly when injected into the blood, more slowly from the subcutaneous cellular tissue, rectum, and conjunctiva, and more slowly still from the stomach. Absorption will occur through the lymphatics,

even when all the vessels of the part to which it is applied have been carefully ligatured. It is often supposed to be absorbed from the bladder, but, according to the author's experiments, this is not the case. Many cases of strychnia-poisoning are either suicidal or homicidal, but not a few are accidental. Most of these are due to apothecaries either dispensing larger doses than have been prescribed, or substituting strychnia instead of other medicine. Some are due to patients taking too much of the prescribed medicine; but others are due to the fault of the physician, who has either prescribed too large doses, or overlooked the cumulative action of the remedy, or prescribed badly. In one interesting case of the last sort, the physician ordered nitrate of strychnia in solution with too small a quantity of solvent. The strychnia, consequently, formed a sediment at the bottom of the vessel, and, on being swallowed, caused the patient's death. In another case, a most instructive one, nitrate of strychnia was prescribed with iodide of iron in solution. The iodine combined with the strychnia, and the sparingly soluble iodide of strychnia formed a sediment, which, when swallowed, caused death. A curious case of poisoning occurred in the person of a doctor in Berlin, who had received a quantity of arrow-poison from Java. He wished to ascertain its physiological action, and, instead of experimenting on animals first, he swallowed three grains of it himself. For a wonder, he recovered, the substance containing no less than 60 per cent. of strychnia. The symptoms of strychnia-poisoning in man are, first, quickened respiration, and afterwards, convulsions of a tetanic character. Sometimes there are general convulsions, but no tetanus. The shortest time in which tetanus has occurred is five minutes, and death in ten. The longest time is tetanus in two and a half hours, and death in six. Where recovery takes place, the convulsions may last twelve hours. The symptoms are similar in mammals, birds, and batrachia. In snakes and white fish there is disturbed respiration, with quivering. In regard to the action of strychnia on single organs, it has been found that it does not paralyze the inhibitory centres of Setschenow; it stimulates the vaso-motor centre, causing contraction of the arteries and increased blood pressure; it renders the olfactory and optic nerves more sensitive, increasing the sense of smell, and the sharpness of vision, as well as enlarging the field of vision for blue and red. In poisonous doses, it produces hyperæsthesia of the retina in dogs. The pupil is dilated to its maximum during the tetanic convulsions, and is normal in the intervals. Strychnia has little action on the heart. It lessens the power of the blood to absorb oxygen. It slightly raises the temperature of the body. It causes contraction of the spleen, and acts upon that organ through the splanchnics. It is said to increase the secretion of urine. When given to a pregnant animal, it exerts but little action on the fœtus in utero. According to the author, the common idea that strychnia acts primarily on the spinal cord is erroneous. On the contrary, it acts primarily upon the brain, its action being exerted on the vaso-motor centre; on the inhibitory centre for the heart; on the respiratory centre so powerfully, that the irritation is propagated from this to the whole system of voluntary muscles; and lastly, on the reflex apparatus of the spinal cord. These actions excite secondary reflex stimuli, starting from the spinal cord and associating themselves with the cerebral ones. After this has lasted some time, the blood becomes poor in oxygen, and this deficiency of itself acts somewhat like strychnia, and the poisoned animals die of asphyxia. The largest fatal dose of strychnia is four milligrammes of the nitrate in a child, and between fifteen and thirty of the sulphate in an adult. In mammals 0.6 milligramme of nitrate of strychnia per kilogramme of body-weight is a fatal dose; for birds 2.0 milligrammes, for frogs 2.1 milligrammes, and for white fish about ten milligrammes. Frogs therefore require a larger dose than mammals instead of being much more susceptible to its action as is generally supposed. All salts of strychnia have almost exactly the same action. After reviewing all the remedies hitherto proposed for poisoning by strychnia, the author concludes that the treatment, if convulsions have not set in, is to empty the stomach by emetics or the stomach-pump, to wash it out with decoction of galls, and combat the convulsions by chloroform. If convulsions have already begun, chloroform must be given at once and the intestinal canal emptied

afterwards. When the poison has been absorbed from a wound, it should be washed, excised, or cauterized. Death from strychnia cannot be diagnosed with certainty from *post-mortem* appearances. The best method of detecting its presence in the stomach or elsewhere is that of Dragendorff. Strychnia is not destroyed by putrefaction of the tissues. Its chief medicinal uses are in paralyses, motor or sensory. It is also employed in chorea, epilepsy, and writer's cramp, dyspepsia, and constipation. The best form is pills, or, still better, subcutaneous injection. The dose for use in the latter should not exceed eight milligrammes.—*Lond. Med. Record*, Aug. 12, 1874.

—
Note on the Nitrite of Amyl.

As the result of some observations published in the *Practitioner* for September, 1874, by Dr. J. CRICHTON BROWNE, Medical Director, West Riding Asylum, it appears that nitrite of amyl, when inhaled during a state of unconsciousness, has a specific action upon the motor centre of the month, and calls into action, by preference, the muscles of the lips and lower jaw. The mode in which it performs this action, whether reflexly or through the agency of the vaso-motor apparatus, is as yet only a subject of speculation. The fact, that the movements which it evokes are consentaneous with the appearance of flushing of the face, gives probability to the latter hypothesis; while, on the other hand, one observation, that when administered hypodermically the nitrite failed to induce yawning in a case in which it had induced it when inhaled, seems favourable to the other view. But whatever may be the explanation of the action in question, there can be no doubt that it is a significant fact, and worthy of further investigation.

—
On the Antiseptic Properties of Salicylic Acid.

The physiological action of this substance has been little studied, though its physical and chemical properties are pretty well known. From the fact that it can be readily composed from carbolic acid and carbonic acid, and that, on heating above the boiling point, it is decomposed into these two substances, Professor KOLBE, of Leipzig, was led to expect that, like carbolic acid, it would oppose processes of fermentation and putrefaction, and prove a good antiseptic. Along with Professor THIERSCH, he made some experiments in this direction, which he has recently described to the Saxon Academy. (See Dingler's *Polytechnisches Journal*, 2d July number.)

To ascertain how salicylic acid acted on ferments, he first dissolved some amygdalin in water, mixed with the solution a small quantity of the acid, and added an emulsion of sweet almonds. In a quarter of an hour, by which time a second mixture of almond emulsion and amygdalin, without salicylic acid, smelt strongly of bitter almond oil, the mixture containing the acid had not the least trace of such a smell. If the proportion of salicylic acid be very small, the smell will appear after some hours; but, with even a small quantity, no smell will be perceptible after twenty-four hours.

Mustard-seed powder, which in lukewarm water soon gives a strong smell of mustard oil, gives no such smell if a very little salicylic acid be previously mixed with it.

If a solution of grape sugar be mixed with a little salicylic acid (a thousandth at the most), yeast has afterwards no action, and a sugar solution already in fermentation ceases to ferment when a small quantity of the acid is added.

Again, some Leipzig beer of excellent quality was divided among several wide glass beakers (1000 grammes to each), and kept fourteen days at a temperature varying between 68° and 75° Fahr., the vessels being covered with loose paper. To one vessel was added (and mixed with the beer) 0.2 gramme of salicylic acid; to a second, 0.4 gramme; to a third, 0.8 gramme; to a fourth, 1.2 gramme; in another glass the beer remained unmixed. This last began at the end of the second day to deteriorate, and became coated with a

layer of fungus. In the vessel with 0.2 gramme of salicylic acid, the fungus vegetation commenced on the third day; in the vessel with 0.4 gramme. on the fifth; in that with 0.8 gramme on the tenth; while the 1000 grammes of beer to which 1.2 gramme acid had been added, did not even after twelve days show any fungus vegetation. Thus a thousandth of salicylic acid, added to beer, suffices to preserve it from injury through fungus growth.

Next, fresh and pure cow's milk, with 0.4 per cent. of salicylic acid added, and left in an open vessel, at a temperature of 64.4° Fahr., was thirty-six hours later of curdling than an equal quantity of the same milk beside it, which was without salicylic acid. The addition of a little more salicylic acid delays the souring and coagulation still longer. The milk continues to taste well; the taste of the small amount of acid is not perceptible.

Some newly passed urine was divided into two portions, and kept several days in separate vessels. A little salicylic acid having been added to one portion, this was found on the third day still clear and free from the smell of ammonia; while the other portion was already far gone in decomposition and smelt strongly.

Fresh meat, rubbed with salicylic acid, will keep for weeks, in air. The author prepared large quantities of beef and mutton with the acid, put them in a large covered vessel, and a month afterwards he found them still quite fit for cooking. Most of the salicylic acid can be removed by washing, before the use of the meat. The remaining portion has a not unpleasant sweet taste, but it is hardly perceptible.

Professor Thiersch made some experiments in the Leipzig Hospital as to the antiseptic action of salicylic acid, and its use in surgery. He says that when strewn (either by itself or mixed with starch) on contused wounds not yet cleaned, and on scurfy gangrenous surfaces, salicylic acid destroys, for a long time, the putrid odour, without any inflammatory action of importance. In solution of one part of salicylic acid, three parts of phosphate of soda, and fifty parts of water, it favours the coating over of granulation-surfaces. As to its action on fresh wounds, the following data are communicated. During the operation the wound is kept under a spray cloud of salicylic acid in water (one in 300). The dressing of the wound consists of wadding, impregnated with salicylic acid in the crystallized state. The wadding is moistened with salicylic acid in water (one in 300), as also the strip of muslin by which it is held. Afterwards, a continuous dripping of the acid solution on the bandage, about eight drops in the minute, is maintained. After an amputation of the femur on April 27, under such treatment, the patient experienced no pain, nor swelling, nor fever. The first renewal of the dressing was on the sixth day. The secretion in the wound during these six days was without smell. With equally good results, Dr. Thiersch performed some other amputations. He is of opinion that salicylic acid has all the advantages of carbolic acid, without its inconveniences.—*London Med. Record*, Sept. 23, 1874.

At a late meeting of the Cincinnati Academy of Medicine, Dr. G. B. ORR stated (*Clinic*, Nov. 7, 1874) that he had given salicylic acid a fair trial, and had found it of great service in a number of cases. He used it as a disinfectant in a very bad case of dysentery, in which there was incontinence of feces, and in consequence the bed became the receptacle; the odour resulting was perfectly horrible, but by sprinkling a solution of salicylic acid of the strength of 1 gr. to 100 parts of water, the smell was entirely removed; not simply overpowered by virtue of its greater strength of odour, for it is odourless.

Dr. Orr again used it in a case of old ulcer of the leg that emitted a most offensive odour, with the effect of not only removing the smell, but it seemed to cleanse the parts so thoroughly that they took on healthy action and the ulcer rapidly healed.

Thirdly, he collected about an ounce of fecal matter, being part of the feces passed by a child suffering from chronic dysentery, put the feces into a large-mouthed bottle, and added about grs. 15 of the acid; at the end of forty-eight hours all smell had disappeared, and at the end of one month there did not seem to have been any change.

Fourthly, Dr. Orr has been making use of it in a compound fracture of the leg, where the injury to the soft parts was quite severe, and up to the present time there has been no suppuration at all, nor indication of it.

Medicine.

On the Hypodermic Use of Atropia in Muscular Rigidities, Rheumatic, and Myalgic.

Dr. J. C. WILSON, of Philadelphia, reports (*Phila. Med. Times*, Nov. 7, 1874) seven cases of muscular rigidity, rheumatic and myalgic, beneficially treated by hypodermic injections of $\frac{1}{80}$ of a grain of atropia, a method of treatment first suggested by Dr. Da Costa (*Penna. Hospital Reports*, 1868).

In the acute form Dr. Wilson has not found atropia beneficial. Hypodermics of morphia, on the other hand, have been serviceable in allaying the pain and inducing repose, but this quite independently of any local action. But later, when the disease has become chronic, or in some cases when it is from the outset of the chronic form and the element of spasm is present with more or less rigidity, atropia used locally is, as the cases show, of prompt and certain benefit. There seems the strongest reason to believe, both from clinical observation and from the researches of experimental physiologists, that the benefit arises from the direct sedative effect of the drug upon the nerve-filaments, and that it thus, by relieving the irritation, relaxing the tonic contractions, and putting an end to pain, enables the circulation and nerve-supply to resume their normal course and relations.

But after a long time, when permanent changes have taken place in the tissues, it is useless to hope that any treatment will restore to the muscles their suppleness and contractility. But even then much may be done by this means in relieving pain, and enabling the patient to avail himself of supplementary and auxiliary muscles in performing customary movements. The effect is the same whether the atropia be injected directly into the muscle or into the subcutaneous tissue overlying it.

On Auditory Vertigo (Ménière's Disease).

(Concluded from page 205.)

We now come to speak of the nature of the ear-disease. We have assumed that the labyrinth is affected, but how it may be affected is yet to be considered. It may suffer primarily or secondarily. There may doubtless occur hemorrhages in it just as these occur in the retina. Knapp strongly urges that aural diseases should be studied in close connection with eye diseases. If we find suddenly occurring nervous deafness, with or without other symptoms of Ménière's disease, there is certainly a possibility of hemorrhage in the labyrinth, and we should inquire into the state of the heart, arteries, and urine, to see if there be a condition for hemorrhage, as we should certainly do if we saw hemorrhages in the retina. Saying nothing further of pathological changes occurring in the labyrinth itself, we speak of other aural conditions which interfere indirectly with it. As the following quotation from Dr. Hughlings Jackson's paper already referred to (see *Medical Times and Gazette*, August 17, 1872, p. 169) is only a compilation, it may be given here, with additions, as a summary.

"Even if it be granted that the semicircular canals are the parts in fault in Ménière's disease, they may be only secondarily so; they may be, indeed, only suffering from some fault in the more external parts of the aural apparatus. Increased pressure (resulting from stoppage of the meatus by wax, by catarrh, acute or subacute, and purulent processes in the cavity of the tympanum),

transferred from the stapes to the vestibulum, must necessarily place the semi-circular canals in an abnormal state of pathological irritation"—(Tröltsch, op. cit.) in other words, the primary changes may be in the non-nervous part of the ear. In syringing an ear in which there is a hole in the *membrana tympani*, we have symptoms essentially like those of Ménière's disease. Dr. Gowers has recently pointed out that Bell's paralysis of the face sometimes comes on with vertigo; considering the relations of the *portio dura* nerve to the ear, this is an important observation. The reporter suggests that the vertigo may be caused by sudden paralysis of the *stapedius*, a muscle supplied by the *portio dura* nerve, and thus be owing directly to non-antagonized action of the *tensor tympani*. It is only in suddenly occurring cases that we can suppose symptoms of Ménière's disease to depend on primary changes in the labyrinth itself. Politzer (quoted and indorsed by Tröltsch, op. cit.) says, "If a person who has formerly heard well becomes suddenly deaf, or hard of hearing, with the symptoms of an apopleptic attack, and there is at the same time an uncertain and staggering gait, but there are no symptoms of paralysis in other nerve-tracts, and if the examination shows a normal *membrana tympani* and perfectly permeable Eustachian tube, we may believe, with great probability, that there is an affection of the labyrinth."—(Tröltsch, op. cit., p. 507.)

We now come to speak of the rare example of Ménière's disease recorded by Charcot. His patient was a woman fifty-one years of age. The vertigo was continual, and very strongly marked. It was present night and day, when lying down as well as when standing up, although in the latter position it was enormously exaggerated, as also when her bed was moved. But occasionally there were seemingly spontaneous aggravations. The following quotation gives a vivid account of her condition. "Sometimes in the midst of apparent calm the patient, as you will no doubt see, is all at once seized with a violent jump. If you ask her the cause of this brusque movement, she invariably replies that she has had an attack. And in fact there are in this patient, besides the vertiginous state which I have tried to describe to you, paroxysmal exacerbations of vertigo, which constitute a kind of attack. They seem to be chiefly characterized by the sensation of a brusque movement of translation, not of surrounding objects, but of the patient herself; a movement entirely subjective, and of which this jumping is the only outward sign. Consciousness is unaffected, and when the attack is over, the patient can describe what she has felt. Sometimes, and most often, it seems to her that she falls headlong forward, at other times the fall seems backward. Lastly, this is the most rare, there is the sensation of rapid rotation of the body round its vertical axis, this rotation being always from left to right. Whichever it be, the motory hallucination is always followed by great anxiety, pallor of the face, and cold sweats. Finally, nausea and sometimes vomiting ends the attack, after which the vertigo subsides, so to speak, to its normal state." The patient always has a whistling in her ears, but occasionally this is acutely increased. This exacerbation of the noise is a warning to her that an attack of vertigo is coming on, and that the jumpings are imminent.

For a long time the patient had had discharge from the two ears of pus mixed with blood. The right *membrana tympani* was thickened, the left was replaced by granulations, and on this side the hearing was considerably enfeebled.

Another remarkable feature was that the vertiginous state had been so severe and continued that for six years the patient had been obliged to keep her bed; before that time she had at intervals attacks but little marked; they became gradually more marked and nearer together until the vertigo and noises were, as stated, permanent, but occasionally exacerbated. It is mentioned that the patient has had attacks of hysterical convulsions, which, however, were independent of the attacks of auditory vertigo. At present the hysteria is only represented by incomplete left hemi-anæsthesia with ovaralgia of the same side.

We conclude this article by a reproduction of Charcot's remarks on it.

"In the first place, I shall show the intimate relation which exists between the sudden development of noises in the ear, or the rapid aggravation of these noises, and the outset of vertiginous sensations. In reality, one of the special characteristics of Ménière's vertigo is that it is always ushered in and accom-

panied by the noises in question. Doubtless the singing, buzzing, and whistling of the ear are very common phenomena, and accompany different kinds of vertigo besides that which is a symptom of Ménière's disease, but in this affection they acquire at the time of the attack a predominance and intensity which is certainly not found in other diseases. As patients say, the noise is harsh 'like the whistle of an engine,' or like the noise which will be made by 'shaking violently a sack filled with nails.' Again, it is compared to 'the firing of guns or of fireworks.' This noise is either exclusively or specially in one ear. In slight or recent cases it ceases with the attack of vertigo. But sooner or later, if the case be a grave one, it becomes persistent, continuing in the intervals in a milder form of singing and buzzing more, or less annoying. Also the affected ear soon shows signs of more or less pronounced and permanent deafness."

After remarking in detail on the nature of the affection of hearing in different cases, Charcot says that there is reason to think, moreover, from the facts as a whole, that any pressure whatever exerted on the tympanum and propagated to the labyrinth by the chain of ossicles is sufficient to produce the symptoms of Ménière's vertigo.

"Considered, however, simply in the character of vertigo, it has some special characters. It is most frequently, if I may judge by the ten or twelve cases of my own, the sensation of a movement of translation of the entire body from behind forward, or from before backward, in a manner to give the patient an idea of a fall forward or backward as the case may be; again when there is added the sensation of moving round a transverse axis, an actual somersault, even a '*saut de tremplin*.' Sometimes the body seems to rotate round a vertical axis either from left to right or from right to left. There are patients who in their different attacks think they have sometimes one, sometimes the other, of these modes of rotation. Remark that generally these movements are entirely subjective, real hallucinations, which only show themselves externally by a start, a movement of surprise, sometimes by the necessity the patient feels of clutching surrounding objects or sitting down. But it may happen that a fall actually takes place, and that the patient is violently thrown to the ground in the sense corresponding to the vertiginous sensation. I may cite, as an instance of this, the case of a lady, who in her attacks always felt thrown head-forward, and who, in fact, in one of them, fell heavily on her face and broke the bone of her nose. I do not deny that the feeling of rotation or of moving is observed in vertiges of the most varying kinds; but I believe I may say that they are not found in any so decided or so constant as in the vertigo of Ménière.

"It is important to observe that during the attack, whatever may be its intensity, the patient preserves absolutely perfect consciousness of his acts, and that when the first effects of the seizure are passed he can immediately, without any confusion, give an exact and detailed account of all he has experienced.

"Under the title of accessory phenomena I shall describe what follows. Almost always, nausea and vomiting mark the end of the attack. While the latter continues the face is pale, the skin cold and covered with perspiration, so as to produce an appearance of syncope rather than of '*coup de sang*.' There may exist a transitory headache, more or less severe. There is never any embarrassment of speech or muscular spasm either of the face or limbs; never any tingling or numbness; no sensations whatever suggestive of aura; never any paralysis nor temporary paresis. At first, that is to say, when the disease of Ménière is yet but beginning, the vertigo appears under the form of distinct crises of short duration, separated by intervals of absolute calm, during which the symptoms of the local disease from which they arise continue alone. But in the natural course of things, as the affection progresses, the crises tend to approach and to be confounded with each other, so as in the end to constitute a permanent vertiginous state, so to speak, in the midst of which occur paroxysms more or less frequent, and which reproduce all the phenomena of the old attacks. The patient I have shown you offers a very decided example of the subintractant crises, which are usually observed, I repeat, in patients who have for years been the subjects of the grave forms of Ménière's disease.

"You will easily understand, gentlemen, the use which may be made of all the elements which I have been bringing together in the interests of diagnosis.

. . . I reserve for another occasion what is known most positively relative to the pathological anatomy and theory. In what concerns the latter, the experiments of Flourens, of MM. Brown-Séquard, Vulpian, Czermak, Gall, Löwenberg, which consist in producing in animals various lesions of the semi-circular canals, have furnished, we do not forget, important results. To-day, I shall conclude by a few words with regard to prognosis and therapeutics.

"It is very remarkable that, as a rule, the grave lesions of the nervous centres, which are so frequently the consequence of different diseases of the internal ear, do not usually occur in Ménière's disease, even when the latter has attained its highest degree of severity. The course of things in the most decided cases is this. The deafness gradually increases, till at a certain moment it becomes complete, absolute.

"The vertiginous symptoms and the whistlings go on, so to speak, at an equal pace, *i. e.*, they gradually decrease and finally disappear. They did so, for example, in the case of the patient of whom I have spoken above, and who in one of his attacks fell on the Place de la Bourse. Subject to the whistlings and vertigo since 1863, he now finds himself quite free from them. But, on the other hand, he is now deaf, so deaf that though he lives close to the Champ-de-Mars he heard absolutely nothing of the explosions of powder in the Avenue Rapp (1871). I am often asked if it would not be well to seek the means by some intersection, of hastening the denouement, at least in grave cases when, for instance, the patients are reduced by it to the lamentable state you have seen in the patient Gir—. It is a point which I offer for your consideration.

"Whatever it be, I must not conceal from you that Ménière's disease often resists the best-directed treatment. I have, however, several times seen vertigo occurring with catarrh of the tympanum decrease, and even disappear, under the influence of the common treatment of the latter affection.

"Here I may remind you of the very interesting case observed by M. Hillairet in which vertigo completely ceased after the opening of an abscess in the middle ear. The application of energetic revulsives must not be neglected in the severe cases. *Après* of these, I will describe a case I saw lately. One of our brethren in the provinces, now forty-four years of age, felt for the first time six years ago some heaviness of the head and buzzing of the ears returning in paroxysms. Some months later, while driving in the country alone, he all at once felt insupportable whistling in the left ear, and at the same time his head becoming heavy seemed to drag him forward. He was obliged to get out of his carriage, and to lie down for an instant upon the road. Nausea, followed by vomiting of glairy matter mixed with bile, ended the attack. Attacks of the same kind have frequently occurred since, and in the mean time the hearing of the ear affected has become feebler. Examination discovers nothing on this side except a certain degree of thickness of the membrane of the tympanum. All treatment tried having failed, I proposed the application of 'pointes de feu' on the left mastoidal region. The applications were repeated three or four times. After this treatment all the symptoms were obviously diminished."—*Lond. Med. Record*, April 29, 1874.

—

On Certain hitherto Unrecognized Movements of the Extremities in Hemiplegics.

A paper in No. 36 of the *Berliner Klinische Wochenschrift*, by M. BERNHARDT, on a special kind of consentaneous muscular movements in hemiplegics, should be studied side by side with one by Dr. WESTPHAL in the last number of the *Archiv für Psychiatrie*. The observation is original, and, so far as we know, forms a new contribution to the incomplete science of nerve action.

Westphal begins by mentioning a few of the various movements that may occur in the limbs of hemiplegics withdrawn from the influence of the will, such as lifting of the shoulder in yawning, sighing, or in voiding excrements. Besides these, it may happen that a hemiplegic, in wishing to contract certain muscles, puts in action their antagonists instead, a phenomenon described some time since by Hitzig. The especial peculiarity of the movement under notice

is, that *when the patient stretches for instance one or more fingers, or the hand of the sound extremity, the movements are executed in an identical manner on the side affected by hemiplegia.*

A brief *résumé* of one of the cases given will illustrate the subject. A man, aged twenty-five, paralyzed from his youth on the left side, was admitted to the *Charité*. Up to his twelfth year the hemiplegic side was subject to cramps, not, however, attended with loss of consciousness. Movements of the hand and fingers on the left side were impossible, unless the corresponding movements were made with the right extremity. As soon as the patient made any movement with the sound (right) side and fingers, this was repeated on the left, and it was quite out of his power to prevent it. A most singular impression was produced by this muscular echo—if the phrase may be allowed; thus, when on one occasion he scratched an itching spot on the face with his right hand, the left was raised for the same purpose. When *passive* movements of the right hand were made, the “echo” was not observed. The muscular sensibility was entirely absent, so that he could not hold anything in his hand without keeping his eyes fixed upon it; the moment he took them off the object dropped. This peculiarity is not invariably associated with the phenomenon in question. The toes and foot of the left side partook of the same morbid “echo.” What is the interpretation of these identical bilateral movements? Let it not be forgotten that Müller, of Coblenz, in 1844, noticed the tendency of muscles to act in groups of association. He remarks that practice is requisite for keeping one eye open, that many are unable to move the muscles of one side of the face only, and that muscles of the extremities are to a less degree so implicated. In early life and in old age the same thing is seen. Westphal thinks that the pathological process which attacked the hemisphere of the side opposite to the paralyzed one spared the large motor ganglia. Thus in left hemiplegia a part of the right brain would be so affected as to be unable to convey will-impulses to the left extremities; from the left brain impulses would continue to be directed on the motor ganglia, and thence through the decussation of the pyramids to the nerves of the right side. But the excitation set up by the influence of the will in the left brain is carried by the commissural fibres to the other side, where, meeting with the still intact large ganglia, it begets a movement in the left extremities, similar to that on the opposite side. The reason why, under ordinary physiological conditions, the same thing does not happen is, that by practice they are suppressed, owing to a restraining influence from the other hemisphere. When elderly persons suffer hemiplegia, these consentaneous movements are not seen, because, according to the above theory, the motor ganglia are affected, whereas, in the affections of childhood, parts only of the hemispheres are affected, as pathology has proved over and over again.

M. Bernhart's remarks are on the case of a boy who, when eight years old, suffered from convulsions after scarlatina, and had right hemiplegia and aphasia, his stock of words consisting only of “yes” and “ah.” The movements in the right shoulder and elbow were slower and made with less force than those in the left; still, to some extent, they could be executed, and, when performed, excited nothing similar on the other side. If a movement were made energetically on the left side—if, for instance, the left forefinger were bent towards the wrist—it was repeated in the right hand, and could not be prevented in spite of all the patient's wishes. If the right hand were rolled up into a “fist,” the left remained quiet, but if the fingers of the right hand were moved alone, then the left fingers, especially the thumb and index, echoed the movement. Closure of the right hand caused only the slightest movement of the left index finger.

Dorso-plantar flexion of the left foot produced an exactly corresponding action in the right foot, though nothing ensued on the reverse movement. The prick of a needle in the left hand only excited movements in the right hand. No opportunity for *post-mortem* verification of Westphal's theory has as yet been offered, but M. Bernhardt agrees with him in the interpretation of the facts.—*London Med. Record*, Oct. 16, 1874.

Reflex movements of the Sound Hand caused by Slight Irritation of the Skin of the Paralyzed Hand.

Dr. PUTNAM reported briefly to the Boston Society of Medical Sciences (*New York Med. Journal*, Nov. 1874), the case of a boy, a patient at the Massachusetts General Hospital, suffering from disease of the aortic valve, who had recently been attacked suddenly with incomplete paralysis of the left side, presumably from embolism, from which he had recovered so as to move his leg freely in bed, though the arm was helpless.

The interesting point in the case was that slight irritation of the skin of the paralyzed hand, such as that made by drawing the point of a pencil lightly across it, caused reflex contractions of the muscles of the opposite hand and arm, causing mainly light flexion of the fingers, hand, and arm at elbow.

In several series of trials these reflex contractions followed the irritations at regular intervals: thus, in the first series, after 12, 11, 17, 16 seconds; in the second, after 4, 6, 4, 12, 12, 14, 30; in the third, after 22, 21, 28, 30. Towards the end of each series of trials, and toward the end of the experiment, the intervals between the irritation and the contractions became longer.

The paralyzed arm and hand did not move except once or twice very slightly, and when it did so the intervals before the movements of the opposite hand occurred were generally longer than usual (v. 2 series, fourth and seventh trials: slight movements of left arm occurred at 4 seconds and 12 seconds, respectively).

It was suggested that the phenomena were due to removal by disease of the inhibitory influence of the right side of the brain over the right side of the spinal cord, although no exact conception could be formed of the conditions which had caused it.

On the Curative Treatment of Insanity by Chlorohydrate of Morphia.

Dr. VOISIN, of the Salpêtrière Hospital (*Bulletin Général de Thérapeutique*, March, 1874), arrives at the following conclusions.

If the malady be recent and not complicated by successions of delusions, the remedy keeps it from progressing, and stops the development of secondary or tertiary stages. Moreover, it calms the general or partial agitation in a time varying from two to three hours after a sufficient quantity has been injected. This dose is very variable, and is only arrived at by experience. The manner in which the delirium disappears is interesting. The delusions, hallucinations, etc., seem to separate off from one another, and no longer to form part of the same whole; they disappear one after another, and the patient replies to questions, and recognizes that he has been ill, his memory returns, and he recounts a series of facts relating to his entry to the hospital, he writes to his family, and allows himself to be treated medically without offering any resistance. It seems as if the symptoms of insanity disappear inversely in the order of their occurrence. Thus the patients who have begun by hallucinations followed up by delusions, in their recovery lose the latter before the former, and though the hallucinations may remain for some days they do not believe in them. The indications for the remedy are: melancholia, with or without hallucination; ecstasy; suicidal ideas; religious delusions; maniacal excitement; the various forms of neuralgia, which are so common amongst the insane, and especially in the women, which often determine the special character of the delusions, giving, e.g., the notion that they are being electrified. The peculiar form of *folie circulaire*, which is generally thought to be incurable, has been very successfully treated by it.

The contra-indications for its use are: inflammatory symptoms, epileptic insanity, and general paralysis. In that form resulting from atheroma of the arteries, it may cause mischief from congestion, leading thence to hemorrhage.

Of the twenty-five cases quoted which were cured, six were affected with general mania, with hallucinations, and incoherence. The strongest dose employed in these six cases was twenty-one centigrammes daily, and the smallest

was thirty-one milligrammes daily, the average duration of the treatment being four months. The other successful cases were of melancholic form, with more or less suicidal and homicidal complication.

Of the five unsuccessful cases, four had delusions of wealth and power, and one had certain febrile complications, a condition which has been shown by later experience to be totally opposed to the proper use of the remedy.

The subject will be continued in another number.—*London Med. Record*, Sept. 4, 1874.

On Syphilitic Meningitis and Syphilitic Cerebral Disease.

In making this valuable contribution to the pathology of syphilis of the nervous tissues, Dr. BRUBERGER (Virchow's *Archiv*, May 6, 1874) narrates with extreme minuteness the clinical history and *post-mortem* examination of a patient who contracted syphilis in 1871, had destructive ulceration of the soft palate two years later, and sudden complete motor paralysis of the arms and legs occurring while under excitement partly alcoholic, partly of another kind. The paralysis was so complete that the patient was unable to move a finger or toe, or make the slightest effort to change his position in bed. Meanwhile, the cutaneous sensibility of the body and limbs was ascertained by many careful experiments to be only very slightly diminished, and the susceptibility of the muscles to electrical stimulus was as keen as in health. The muscles of the face and of respiration were not paralyzed, nor was control of the sphincters wholly lost. Consciousness was lost only for a few moments, and having returned, remained unimpaired to the last. The intellect was also intact. Iodide of potassium, in large doses, was administered for four weeks, and then changed for mercurial inunction. Six weeks after admission the patient regained the power of slowly clenching the fist and opening the hand again, but no other improvement ensued. After lingering nearly four months, he sank exhausted by bed-sores and vesical irritation. In making the diagnosis, no hypothesis explained all the symptoms. The bilateral symmetry of the motor palsy and the unimpaired sensorium suggested the cord to be the part attacked. The suddenness of onset indicated extensive hemorrhage or plugging of a large artery, were it not that in syphilis paralysis does occur suddenly without either of these conditions being found after death. Again, a thrombosis or hemorrhage would have almost certainly produced some hemiplegia. Local softening or the presence of a gumma in the medullary tissue was, like hemorrhage, precluded by the undiminished intellectual power. Lastly, disease of the meninges at the base, a frequent form of cranial syphilis, was rendered improbable by the absence of peripheral irritation of all kinds; neither convulsions nor slowness of pulse, nor sinking in of the abdomen, etc. were present. But the *post-mortem* examination revealed most unexpected conditions, the principal being inflammatory thickening of the dura and pia mater in the cervical portion of the spinal cord and base of the brain, producing a leathery sheath which had formed numerous attachments to the medulla and to the bony surfaces. There were also hemorrhages into the spinal cord, with atrophy of the gray substance and considerable widening of the central canal. In the skull, inflammation had spread widely through the meninges over the basilar bone, and had changed the pia mater at the base of the brain into a thick gray glue-like mass. Another striking alteration was a peculiar change in the vessels of the skull, causing thickening of their walls and a nodular condition of their calibre; the arteries throughout the rest of the body being free from perceptible change. The remaining phenomena had nothing specially syphilitic. The author then recapitulates the points of interest in the case, and has collected the published records of syphilitic disease in arteries, which consist mainly of the observations of Hughlings Jackson, Moxon, and Clifford Allbutt, and of one or two others. These observations show that ordinary atheroma, if at all a syphilitic product, is not the usual arterial affection, which consists of irregular thickening of the coats, especially of the middle tunic of the vessel, producing nodular projections with narrowing and some loss of elasticity of the vessel, but no fatty or calcareous degeneration of its walls: further, that this

inflammatory change of the arteries is very local, attacking the vessels of one or two regions, and not spreading through the arterial system generally. After remarking that the extensive disease of the meninges caused no convulsive affection of any kind, again a peculiarity of syphilitic meningeal disease, the author notes, without offering an explanation, the curious fact that sensation was intact throughout the body, and yet the gray matter of the cord was far advanced in atrophy, while the white fibres were so tightly strangled at one point of the medulla as to produce almost total loss of voluntary muscular power.—*London Med. Record*, July 8, 1874.

—

On Ipecacuanha Spray in Winter Cough and Bronchitic Asthma.

Dr. SYDNEY RINGER and Mr. WILLIAM MURRELL in a communication to the *Lancet* (Sept. 5, 1874) state that "the successful use of a secret remedy by a well-known practitioner induced us to try the effect of inhalation of ipecacuanha spray. Our results have been so satisfactory that we desire to draw the attention of the profession to this mode of treating these obstinate complaints—winter cough and bronchial asthma. Our observations were made during January and February. Whilst under this treatment the patients took only coloured water, and continued their usual mode of living in all respects.

"We shall first refer to winter cough. We have made observations on twenty-five patients, whose ages varied between forty-five and seventy-two, with one exception—that of a woman of thirty-two years. We purposely chose severe cases."

In winter cough "our results have been very striking, although in many of our patients so bad was the breathing that, on being shown into the out-patients' room, they dropped into a chair, and for a minute or so were unable to speak, or only in monosyllables, having no breath for a long sentence. We used the ordinary spray-producer, with ipecacuanha wine pure or variously diluted. On the first application it sometimes excites a paroxysm of coughing, which generally soon subsides, but, if it continues, a weaker solution should be used. The patient soon becomes accustomed to it, and inhales the spray freely into the lungs. At first a patient inhales less adroitly than he learns to do afterwards, as he is apt to arch his tongue so that it touches the soft palate, and consequently less enters the chest than when the tongue is depressed. The spray may produce dryness or roughness of the throat, with a raw sore sensation beneath the sternum, and sometimes it causes hoarseness; whilst, on the contrary, some hoarse patients recover voice with the first inhalation. As they go on with the inhalation, they feel it getting lower and lower into the chest till many say they can feel it as low as the ensiform cartilage.

"The dyspnœa is the first symptom relieved. The night after the first application the paroxysmal dyspnœa was often improved, and the patient had a good night's rest, although for months before the sleep was much broken by shortness of breath and coughing. The difficulty of breathing on exertion is also quickly relieved; for often after the first administration the patient walked home much easier than he came to the hospital, and this improvement is continuous, so that in one or two days or a week the patient can walk with very little distress, a marked improvement taking place immediately after each inhalation; and although after some hours the breathing may again grow a little worse, yet some permanent improvement is gained, unless the patient catches a fresh cold. We have heard patients say that in a week's time they could walk two miles with less distress of breathing than they could walk a hundred yards before the spray was employed. In some instances two or three days' daily spraying is required before any noticeable improvement takes place, this comparatively slow effect being sometimes due to awkward inhalation, so that but little ipecacuanha passes into the bronchial tubes. The effect on the cough and expectoration is also very marked, these both greatly decreasing in a few days, though the improvement in these respects is rather slower than in the case of the breathing. Sometimes for the first few days the expectoration is rather increased. It speedily alters in character, so that it is expelled much

more readily, and thus the cough becomes easier, even before the expectoration diminishes.

"Treated in this way the patient is soon enabled to lie down at night with his head lower, and in a week or ten days, and sometimes earlier, can do with only one pillow. This improvement occurs in spite of fogs, damp, or east winds—nay, even whilst the weather gets daily worse, and when the patient is exposed to it the chief part of the day. All these patients came daily to the hospital. Of course it is much better to keep the patient in a warm room."

"All but one of the twenty-five patients were benefited. In one case the improvement was very gradual, but there was evident temporary improvement after each inhalation. In twenty-one cases the average number of inhalations required was 9.4, and the average number of days was twelve, before the patients were discharged cured. The greatest number of inhalations in one case was eighteen, and the smallest three. The case longest under treatment required twenty-four days; the shortest, four.

"In employing the ipeacacuanha spray, in order to insure as far as possible only its topical effects, we were careful to direct the patient to spit out and even to rinse out the mouth at each pause in the administration, for a much larger quantity of the wine collects in the mouth than passes into the lungs. If this precaution is not adopted, sometimes enough is swallowed to excite nausea, and even vomiting, by which means the bronchial mucus is mechanically displaced, and, of course, in this way effects temporary improvement. Even when this precaution was observed, a protracted inhalation will excite nausea and sometimes vomiting by the absorption of the wine by the bronchial mucous membrane; though, strange to say, when thus induced, vomiting was long delayed, even for several hours—nay, sometimes not till the evening, though the inhalation was used in the morning. In the reported cases, however, improvement was not due to the nauseating effects of the spray, for we took care to avoid this contingency by administering a quantity inadequate to produce this result. The duration of each inhalation will depend on the amount of spray produced by each compression of the elastic ball, and on the susceptibility of the patient to the action of ipeacacuanha. As a rule, the patient at first will bear from twenty squeezes of the spray without nausea, and will soon bear much more. After two or three squeezes, especially on the commencement of the treatment, we must pause a while. It is necessary to look at the patient's tongue and tell him to learn to depress it, for if the tongue is much arched it will hinder the passage of the spray to the lungs. It is a good plan to tell the patient to close his nose with his fingers, and to breathe deeply. The inhalation should be used at first daily, and, in bad cases, twice or thrice in the day; afterwards every other day suffices, and the interval may be gradually extended. If the ipeacacuanha wine is diluted, then the spray must be used a longer time. In cold weather the wine should be warmed."

On the Use of Carbolic Acid in Cheesy Pneumonia.

Professor TOMMASI states (*Il Morgagni*, January, 1874, quoted in *Gazzetta delle Cliniche*, May 19) that he has found carbolic acid very useful in cases of cheesy pneumonia which have gone on to the formation of pulmonary abscess. The medicine is administered in the form of solution (one part in forty of water, sweetened). In two years he has met with six cases, of which he relates two.

The first case was that of a boy, aged six, who had hectic, sweats, extreme emaciation, and moderate expectoration of sanguineous fetid pus. Cinchona, lactate of iron, cod-liver oil, and raw meat produced but little improvement. He now had half a gramme of the carbolic acid solution daily, the dose being increased to a gramme. At the end of a fortnight the fever ceased, the expectoration diminished and became inodorous, and in four months he was quite restored to health.

In the second case, there was abundant expectoration of inodorous pus. The usual restorative means failed; but, after the solution of carbolic acid had been given in daily doses of a gramme to a gramme and a half, the expectora-

tion diminished, and the patient became free from hectic and regained his appetite, and his nutrition was improved. In two months the expectoration had ceased, and a respiratory murmur, though weak, could be heard in the portion of lung which had been hepatized.—*London Med. Record*, Sept. 2, 1874.

—
On the Symptoms of Tuberculization in Children, and their Semeiological Value.

Dr. J. GRANGÉ (*Thèse de Paris*, abstracted in *Revue des Sciences Médicales*, 1874) has sought to define more clearly than has yet been done, the exact physiognomy of tuberculous children; as well as the importance of the various symptoms presented in them. Unfortunately tuberculosis shows itself under so many forms, is so common during infancy, and develops itself in so different a manner, according to the parts most directly attacked, that it is difficult to give a connected account of symptoms which differ widely. After describing the signs afforded by examination of the thorax, the respiratory movements, and the dyspnœa, Dr. Grangé proceeds to study the fever of tuberculosis. He points out the marked variations of the thermal curve, according as the inflammatory phenomena advance more or less rapidly; but whatever may be the character of the phthisis, it is thermometrically distinguished by the amplitude of its daily oscillations, and the great difference between the morning and evening temperatures. On the contrary, tuberculization of the peritoneum causes but a slight increase of temperature; indeed, when it is unattended by complications of an inflammatory nature, the temperature is lowered. In meningeal tuberculosis the temperature is very low at the stage when the phenomena of cerebral depression become manifest. The thermometer may indicate important differential signs in cases where the presence of typhoid fever might be supposed. Dr. Grangé then proceeds to study carefully the symptoms of pain, vomiting, and disturbance of the cutaneous and secretory functions; but as these symptoms differ but slightly from the corresponding disorders from which adult phthisical patients suffer, and as their very diversity is unfavourable for generalization, there is nothing striking or original in this section of his researches. This treatise contains a useful series of tracings of thermic waves taken from tuberculous children, and a considerable number of notes of cases; among which some, taken with great care, relate to cases of cerebral tuberculosis and tuberculous meningitis.—*Lond. Med. Record*, Oct. 4, 1874.

—
On Acute Phlegmonous Periostitis with Ulcerative Endocarditis.

M. HIRTZ, in the *Progrès Médicale*, p. 413, reports a case occurring in a girl eight years old. Up to five years previously she had never had any ailments, when she was suddenly seized with pain in the left thigh; an abscess formed which was opened and healed in a fortnight. Four days previously to her entry into the hospital the child was suddenly attacked with violent headache. She became delirious the same night, and continued so. At the same time the left thigh began to swell and be painful. On admission, the patient was very restless; she lay on her back with her eyes fixed, and had sudden attacks of terror. The chest-sounds were normal, the heart-beats very rapid. The left thigh was swollen and painful to the touch. M. de Saint-Germain diagnosed phlegmonous periostitis. He thereupon made a deep incision, from which blood and a little pus escaped. The child sank on the fourth day after admission. The necropsy showed the periosteum thickened and separated for the whole of the lower third of the femur. The surface of the bone was rough, covered with osseous stalactites, and a thin layer of pus. A section displayed islets of osteomyelitis. The meninges of the brain were congested. In the left lung, at its base, was a small infarctus. The right side of the heart was sound. Just below the aortic valves were three small ash-gray ulcerations, surrounded by a red zone.—*London Medical Record*, Oct. 7, 1874.

On Hepatic Syphilis in the Adult.

Hepatic syphilis, as M. LACOMBE observes (*Progrès Médical*), is at once an old and a new question. It is old in fact, for the medical men who came after the Renaissance attributed to the liver, which played a prominent part in the vital functions, the seat of a disease which exercised so serious an influence over the animal economy; and yet new, since really scientific researches on syphilis only date from about twenty-five years since. Dittrich's first memoir only appeared in 1849, and subsequent researches but serve to consolidate and complete the work of the physician of Prague. A considerable number of medical men, however, in France and other countries, have added their stone to the general edifice. Gubler in 1852, Quetelet in 1856, Lecontour and Virchow in 1858, Leudet in 1860, Lancereaux, Cornil, and Ranvier, have brought to light all the variety and capriciousness belonging to the clinical and anatomopathological manifestations of this disease. In the anatomical portion of his work, M. Lacombe recognizes and describes two principal forms in lesions of the liver, interstitial hepatitis, and gummatous hepatitis, of which he gives the histological description in detail, from the works of MM. Lancereaux, Cornil, Ranvier, and Hayem, afterwards going into an interesting discussion on the unity or duality of the sympathetic lesions of the liver. We know, in fact, that the generality of writers consider interstitial hepatitis and gummatous hepatitis to be of totally different orders; the first they hold to be of a purely inflammatory nature, whilst the second alone is markedly a specific disease. M. Lacombe is of a different opinion, and believes that the anatomical nature of the lesions is identical, all the difference between them arising from the fact that they do not attain to the same degree of evolution. The question is, at what stage of syphilis hepatic lesions appear. It is difficult to solve this question in a general way, for syphilis of the liver is often latent, sometimes is only found out on necropsy, and may last a long time without betraying its existence; whence the difficulty. It does not appear possible to say whether, as some writers think, the diffuse lesions are always primary, and the circumscribed lesions, the gummata, are always consecutive.

In a second and clinical portion of his work, M. Lacombe traces the symptomatological history of hepatic syphilis, and includes a number of unreported cases collected by him in the hospitals, or given to him by his colleagues, MM. Rendu, Troisier, Homolle, Raymond, etc. A certain number of these cases gain special value from microscopic examination, generally made by M. Hayem, who even describes a lesion not pointed out before he did so, and which he calls perilymphangitis; the meaning of this term being that the lymphatics have increased in number, and that many of them are dilated and surrounded, as it were, with a ring of connective tissue. The concluding chapters of this valuable monograph relate to the icterus of secondary eruptions. They inquire into the nature of that icterus to which M. Gubler specially drew the attention of the profession in 1853; whether they depend on syphilis, and by what mechanism they are produced. The influence of syphilis on the development of icterus is scarcely to be contested at the present day, for observation has sufficiently proved that that icterus is etiologically connected with syphilitic manifestations. The author passes in review all the opinions hitherto enumerated concerning the mechanism by which it is produced, and takes his stand on that which pronounces that the icterus which is coincident with premature syphilitic eruptions is a simple catarrhal icterus, only differing by its cause from the more ordinary catarrhal icterus.—*London Med. Record*, Oct. 21, 1874.

Pseudo-Membranous Enteritis.

M. WANNEBROUCQ (*Le Progrès Médical*) read a paper at the recent meeting of the *Association Française pour l'avancement des Sciences*, on this form of enteritis, which, he said, merited a special description. Up to the present time it had been but little studied by authors, who seemed to regard it as of less frequent occurrence than it really was. It had also received the name of croupous ente-

ritis, and ought to be connected with what was termed sporadic dysentery. The peculiar character of the disease consists in the expulsion of false membranes, at first small and short, but which soon become thick, and extend to a length of from 15 to 30 centimetres (6 to 12 inches), and in exceptional cases even to a length of a metre (1 yard $\frac{1}{10}$), and even a metre and a quarter, as in a case observed by the author. Their form is variable, resembling sometimes the segments of tænia, while at other times they are tubular, or present the appearance of frog's spawn. The disease is ushered in, in the acute form, with very analogous symptoms to those of enteric fever (but neither rose nor slate-coloured spots have been ever observed), and there is a remarkable tendency to pass into a chronic state. The expulsion of false membranes often lasts for months, or even years, without occasioning serious derangement of the general health. The anatomical lesions do not differ from those of chronic enteritis. The small intestine is never engaged, but always the large intestine, either the cæcum or colon, or the rectum; in the latter case the symptomatology is that of dysentery. Another point worthy of attracting the attention of the observer, is the frequent, almost constant, coincidence of nervous affections in the subjects of this form of enteritis. These affections present themselves in the female under the form of hysteria, in all its varied aspects, and in males chiefly in different kinds of hyperæsthesia, and in hypochondriasis. From these circumstances M. Siredey regards pseudo-membranous enteritis as a neurosis with disorder of the secreting system. Would it not be more correct to consider these nervous derangements as secondary and subservient to the influences of the visceral derangements?—*Irish Hospital Gazette*, Oct. 1, 1874.

Surgery.

On the Treatment of Wounds.

Dr. G. M. HUMPHRY, at the recent meeting of the British Medical Association, presented (*British Medical Journal*, Sept. 19, 1874) a paper upon this subject. Cut surfaces, he said, seldom fail to adhere together and grow together—that is, to unite by first intention—if they be kept in apposition, however much they may have been exposed to air, as in wounds of the face, scalp, and fingers, where this may commonly be done. This, therefore, is the great desideratum. The obstacle to it is the accumulation of bloody fluid in the wound keeping the surfaces apart, decomposing, and causing suppuration. No precautions hitherto have assured against this. Anything giving that assurance would be a most valuable discovery. The decomposition may be lessened sometimes, though not commonly prevented, by antiseptics, but fail to provide for escape by drainage. Professor Humphry had long adopted the plan, which he had brought before the Association at the Cambridge meeting in 1864, of approximating the edges by sutures, and leaving the wound quite uncovered and dry. No dressing being used, the pain of removing and reapplying plasters, etc. is avoided. This, combined with some antiseptic or blood-coagulator to the surface of the wound, and a space left for escape of bloody fluid, was, he believed, the mode most likely, on the whole, to promote quick union of large deep wounds. He did not think that torsion of vessels or carbolized ligatures presented much advantage over the hemp ligature. A splint was an adjunct that might well be oftener used. He had tried the hydrate of chloral (five to eight grains to the ounce of water), and found it a valuable disinfectant, and recommended others to try it. In the case of wounds for the removal of cancer, he had for many years encouraged suppuration, and tried to retard healing, believing that this tended to delay the return of the disease. In some cases, he had inserted issues at the time of the operation or subsequently, and he thought with benefit. He believed the administration of opiates to be generally prejudicial in the treatment of wounds.

On Herpes Corneæ.

Dr. PFLUGER, of Luzern, relates a case of herpes corneæ, in Zehender's *Klinische Monatsblätter für Augenheilkunde* for April and May, depending upon excessive use of the eyes by artificial light. After trying the usual modes of treatment by atropia, rest, iodide of iron, quinia, arsenic, etc., without effecting any change, he applied a constant current, placing the anode on the closed lid, directly over the cornea, and the cathode on the neck. Under this treatment, applied daily for from five to ten minutes, only one new crop of three vesicles appeared, while formerly there had been a new daily crop of from eight to twelve.—*Lond. Med. Record*, Sept. 2, 1874.

On Serous Cysts of the Iris.

In Zehender's *Klinische Monatsblätter für Augenheilkunde* for April and May, Dr. HOSCH, of Basel, and Dr. SATTLER, of Vienna, have papers on the serous cysts which occur in the iris. The theories given as to their origin are discussed, that of Von Wecker being that all such cysts have their origin from the folding in and attachment of such folds of the iris, either with or without a wound in the cornea; while Rothmund holds that they have their origin only by the carrying of corneal epithelial cells into the iris, after or during the infliction of a corneal wound, and that these cells increase in their new position, secrete, and so form a cyst within the iris tissue itself. Dr. Hosch describes the microscopic anatomy of an eye, in which an iris-cyst had occurred after a wound, and which was removed on account of sympathetic ophthalmia of the other eye. The cyst was about five millimètres deep, lying in the tissue of the iris on the one side, while on the other side it was bounded by the ciliary body, sclera, conjunctiva, and cornea. He thinks there had been a division in the iris-tissue arising from a wound at the corneo-scleral junction, which, after the consequent collapse of the anterior and posterior chambers, and the soldering of the anterior and posterior surfaces of the iris to the neighbouring tissues, had been, on the closure of the anterior wound, filled by the reaccumulation of the aqueous humour, and so formed the cyst. He considers that the case goes to support Von Wecker's theory as to the origin of such cysts.

Dr. Sattler had the opportunity of making microscopic examinations of three such cysts, and found that in all three the wall was composed of fibrous tissue, with a lining of large flat cells, consisting of several layers. In these cases, he believes he established the following facts: 1. The preceding of, and in itself a trifling wound; 2. The presence of a cicatrix at the corneo-scleral boundary; 3. The commencement of the cystic formation long after the wound; and 4. The after-appearance of irritable conditions by the increase of the cyst, and the clothing of its inner surface by a variably thick layer of flat cells. He thinks that the elements of these epithelial layers not only increase by division of the epithelial cells present, but receive additions from the cells in the stroma. In one case he found what he calls an anatomical peculiarity, capillaries in the walls of the cyst. Dr. Sattler is not fully satisfied with any already proposed theory of origin.—*Lond. Med. Record*, Sept. 30, 1874.

On Pulsation of the Retinal Arteries in Aortic Disease.

The appearance of pulsation within the retinal veins is well known, but when met with in the arteries it is generally accepted as an indication of disease. Most observers agree with Von Graefe in the belief that its occurrence implies an increase in the intraocular tension. Dr. GRANDCLEMENT considers this explanation to be by no means complete, inasmuch as the phenomenon has lately been associated with aortic disease. The first observation to this effect was that of Quinke (1868); and independently, an observation of a similar case was communicated (1871) to the Ophthalmological Congress at Heidelberg, by Otto Becker; and in an article entitled "The Movement of the Blood Visible in the Human Retina," and published in the *Berlin Archives*

(1872), Becker has recorded seventeen cases of its occurrence with heart disease. In cases of aortic insufficiency, with or without hypertrophy of the left ventricle, Becker has observed pulsations in the arteries of the optic disk; and in a case of supposed aortic disease in which the pulsation could not be detected, the subsequent necropsy revealed an aneurism of the ascending aorta, with no disease of the aortic valves; on the other hand, the occurrence of pulsation enabled Becker to correct a diagnosis of aneurism where there was in fact disease of the aortic valves.

Dr. Grandclement (*Lyon Médical*, June 7, 1874) has been able to verify these observations of Becker, in the case of a young woman aged twenty-seven, who was in the last stage of heart disease; the heart's action was feeble and irregular, and its two sounds were almost obscured by a loud double murmur, which was prolonged into the carotids. The phenomena of pulsation were very evident in both the branches of the central artery of the retina; it should be said, however, that the appearances were rather those of alternate filling and emptying than those of true pulsation, for during the heart's diastole these vessels were reduced to mere threads, and during the systole they regained their usual size and colour. No other intra-ocular lesion could be detected, and, except of an occasional passing dimness of vision, no complaint was made.

The occurrence of a visible arterial pulsation within the eye when in perfect health, has been noted in some instances by Donders. The observations of Helmholtz do not support the fact of its occurrence, and some experiments made by Becker upon the mesentery of frogs would seem to contraindicate it. In these experiments the action of the heart was seen to produce an acceleration in the movement of the blood, but not an actual pulsation of the bloodvessels; only when a vessel divided into others of lesser calibre could any pulsation be detected, and, in consequence, Becker asserts that when arterial pulsation is observed in the healthy eye, it is either transmitted from the adjacent veins, or it occurs at the bifurcation of the arterial trunks. He gives, however, no explanation of its occurrence with heart disease, which Dr. Grandclement thinks can be explained as follows. He supposes that in a state of health the intra-vascular tension and the intra-ocular tension are so evenly balanced that no pulsation or alteration in the size of the arteries can be detected; when, however, the harmony between these is disturbed, either by the increase in the one, or by the depression of the other, the phenomena of pulse are at once apparent. Thus when the intra-ocular tension is increased, as in glaucoma, the calibre of the arteries during the heart's diastole is considerably reduced, and during the systole is again restored; by reversing the order of things, and supposing the intra-ocular tension to be normal, and the intra-vascular tension to be depressed, as in the later stages of aortic disease, the same appearance of pulsation would be noticed.

The explanation, then, of the pulsation of the retinal vessels in glaucoma and in cardiac disease, consists in the want of harmony between the intra-ocular tension and the intra-vascular tension in the arteries upon the optic disk. In the same way Dr. Grandclement explains that a retinal pulse should occur in cases of rapid and abundant hemorrhage.—*Lond. Med. Record*, Aug. 26, 1874.

On a New Method of Operation for Entropion and Trichiasis of the Upper Eyelid.

The *Annales d'Oculistique* for May and June, 1874, contains an account of a new operation for the cure of these troublesome and distressing cases, and one which Dr. WARLOMONT has practised with great advantage. After passing in review the methods recommended by Anagnostakis, by Von Graefe, by Williams, and by Streatfeild, all of which are good in their way, but each and all leaving something to be desired, Dr. Warlomont describes and recommends his own plan of proceeding as presenting the following advantages:—

1. The operation may be as extensive as the surgeon pleases.
2. A recurrence of the inversion is rendered impossible.

3. The skin of the eyelid is unhurt, and the subsequent sear is almost imperceptible.

The operation consists in detaching the margin of the eyelid, with the offending eyelashes, from the subjacent tissues, and fixing it by sutures to the upper border of the tarsal cartilage, previously laid bare by a careful dissection. It is carried out as follows:—

The patient is placed under chloroform, and the upper eyelid is fixed and compressed by a modified form of ring-forceps, which will be subsequently described. An incision is then made through the skin only, parallel to and at a short distance from the ciliary margin; the skin is then dissected from the orbicularis muscle as far upwards as the ring of the forceps, so that a semi-lunar flap is formed of integument alone. The margin of the eyelid is then transfixed from above by a narrow double-edged knife, which detaches the row of eyelashes, or so much of it as is required, in such a way as to split the margin of the eyelid into halves, except at the extremities of the section. The narrow flap of integument containing the eyelashes is then drawn upwards, and is fastened by three or more sutures to the upper margin of the tarsal cartilage, which has been exposed by the previous dissection of the skin. The margin of the eyelid, bared of its eyelashes, is left to granulate over, and the flap of integument falls naturally into position, and requires no sutures. The threads are removed at the end of three or four days, when the union is generally found complete.

The ring-forceps which Dr. Warlomont employs is a modified variety of those generally in use. There is, as he says, a well-known objection to the ordinary form of instrument, in that its grasp upon the eyelid is limited, especially in breadth, so that it very often fails to include the entire row of eyelashes upon which the surgeon may wish to operate, and thus the operation is rendered incomplete. With the forceps which Dr. Warlomont has devised, this disadvantage is overcome in an ingenious manner; the upper blade or ring is made to expand laterally, by means of a screw, and may thus be adapted to any length of the eyelid that may be desired; at the same time, and by a similar arrangement, the under and solid blade can be made to expand like a fan. The instrument was originally described by Dr. Warlomont in the *Klinische Monatsblätter*, December, 1873, having been previously mentioned at the Heidelberg Congress. It is now fully described, with an illustration, in the May and June number of the *Annales*, and with some improvements.

The instrument has been called the “fan-shaped eyelid forceps,” by Dr. Warlomont.—*London Med. Record*, Sept. 2, 1874.

Removal of Plaster of Paris from the External Auditory Canal.

Mr. DALBY related at a recent meeting of the Clinical Society of London (*British Med. Journal*, Oct. 17, 1874), the method he had employed to extract some plaster of Paris which had become moulded and hardened in the external auditory meatus. The accident had occurred to a gentleman while he was having a cast taken of his head, and the plaster at that time had found its way into the meatus, and rapidly hardened. It partially filled the passage, was in close contact with the tympanic membrane, and caused complete deafness and considerable tinnitus. The following was the plan adopted. Whilst light was thrown through the speculum worn on the forehead, strong hydrochloric acid was applied on the end of a pointed piece of wood, drop by drop, to the centre of the mass, care being taken not to allow any of the acid to touch the meatus. Several drops of the acid were thus applied on four occasions, and the concretion became so far softened that a small hole could be drilled into it with a cataract needle, and pieces were from time to time picked out with a little hook, which was in common use among dentists. The great mass of the plaster, however, was softened by the application of acetate of lead, the action of which was to convert the sulphate of lime into sulphate of lead and acetate of lime. The latter salt being very deliquescent, the consistence of the plaster was so altered that the whole of it was finally piecemeal removed with the hook referred to.

Throughout the proceedings, which occupied eight sittings of about half an hour each, reflected daylight was employed. The tympanic membrane was found uninjured, and the hearing unimpaired.

On Salivary Fistula.

In a recent number of the *Gazette des Hôpitaux* (p. 814) is the account of a patient who was exhibited to the Académie de Médecine after the cure of a salivary fistula. He was a boy aged twelve, who fell in running down a staircase with a chamber-pot in his hand. His cheek was cut, and three fistulous openings formed—one corresponding to the situation of Steno's duct, which showed no tendency to heal, the two others situated over the gland itself closed spontaneously. An artificial canal was formed through the cheek, by means of a trocar, and kept dilated with tents and bougies. When this canal had been completely established, the wound was closed by twisted suture. The cure at the time of exhibition (more than three months after the accident) seemed complete. During the presence of the fistula, Dr. PROMPT, his medical attendant, made several observations on the boy which led him to the following conclusions.

1. The discharge of parotid saliva depends on the excitation of the sense of taste, and is pretty nearly the same whatever be the form of that excitation, whether the person eats or drinks, or a sapid substance is applied to the tongue.

2. The quantity of the liquid secreted depends chiefly on the time during which the excitation of the sense of taste lasts; thus, if a glass of wine is swallowed at once, only a few drops will be secreted; if it be drunk in small mouthfuls, so as to spend three or four minutes over it, a considerable quantity, as much as two or three grammes, will be obtained.—*London Med. Record*, Oct. 7, 1874.

On Gastrotomy for Internal Strangulation.

Professor BERTI, of the Leghorn Hospital, in the memoir of which an abstract is given in *Lo Sperimentale* for July, describes the case of a man, aged about sixty, the subject of an old right inguinal hernia, which he had always kept up by means of a truss. During a violent effort, he suddenly felt pain in the groin which was the seat of the hernia; and intestinal obstruction, with distension of the abdomen, hiccough, and vomiting of food (but not of fecal matter) set in. From a careful examination of the case, Dr. Berti arrived at the conclusion that the obstruction was caused by a constricting band acting on a part of the bowel not very near the stomach. He accordingly made an incision about four inches long, and laid open the inguinal canal. Here he found a hard mass of omentum, from which proceeded a cord, passing into the abdomen by the internal ring, which guided him to the constricting band. The finger being introduced, this band was divided by means of a knife, and the intestine was set free. The cord was then drawn out and cut off. It was a little time before the bowels recovered their power of acting, and an oleaginous purgative was required, but the patient was quite well in less than a month.—*London Med. Record*, Aug. 26, 1874.

Case of Perityphlitis; Operation on the Eighth Day; Recovery.

Dr. CHARLES KELSEY, of New York, reports (*Medical Record*, Oct. 1, 1874) the following case.

L. C., age 16, French, previously in excellent health, was taken on the eve of April 8, 1874, with pain over abdomen and vomiting, lasting all night. Next morning, after an enema, had three good passages from bowels, the vomiting ceased, and pain became localized over right iliac fossa.

April 10. Pain increasing in fossa; great tenderness on pressure; sleeplessness; some fever. A dose of castor oil given by parents was followed by one passage from bowels, in fair quantity.

11th. No improvement in pain. Physician sent for.

At first examination near the end of the third day of trouble, the patient was found, temperature 101.5, pulse 120, and a hard, painful tumour in right iliac fossa. There was dulness reaching half way from ant. sup. spine to umbilicus, and for about an inch and a half of this distance flatness on percussion. There seemed to be also a slightly greater fulness on the surface over this fossa than on the other side, but no redness or fluctuation.

Persistent questioning failed to reveal that patient had eaten anything liable to become fixed in appendix.

Ordered Sol. Magendie, q. s., to relieve pain.

12th. Condition unchanged.

13th. Small, voluntary mucus passage from bowels.

14th. Pain, tenderness, and swelling in fossa continue undiminished, slight increase in area of dulness. Pulse ranges from day to day at about 110, and temperature about 101.5. These are the only symptoms—no vomiting, no chills, no pressure affects firm tumour.

16th. (Morning of eighth day.) Case seen by Dr. George A. Peters in consultation. At this time the border of tumour, as well as could be felt by deep pressure on abdomen, extended about half way between ant. sup. spine and umbilicus; but for some distance further there was dulness and tenderness. Temperature 101, pulse 110. The tumour had not increased in superficial area for forty-eight hours, and there was no redness or fluctuation.

The diagnosis was confirmed by Dr. Peters, and with his approval and assistance, and that of Dr. Abbe, the operation was performed.

The incision was four and a quarter inches long, beginning at a point one inch above ant. sup. spine, and running parallel with, and an inch above, Poupart's ligament. After cutting through the external oblique, the smallest needle of aspirator was plunged into the tumour, and a few drachms of pus drawn out. The incision was then carried on to transversalis fascia, and a large-sized aspirator needle again used, through which there was an escape of foul gas and pus, without it being necessary to attach the instrument.

Leaving this second needle in as a guide, an incision an inch long was made through the fascia, and two or three ounces of pus escaped.

The cavity of the abscess was carefully explored with the little finger, and the convoluted intestines could easily be felt, apparently covered by the parietal layer of peritoneum separated from the fascia by the collection of pus. But this could not be decided positively; nor could it be found with certainty whether there had been perforation of the appendix or colon, though it was thought by two of us that there was a marked fecal odour about the pus and wound immediately after the abscess was opened.

Wound kept open with lint, and poulticed.

Next day the temperature was normal. Pulse 98; pain greatly relieved; wound discharging well; patient much improved every way.

22d. One large passage from bowels, assisted by enema.

After this the bowels moved easily and readily every day or two, and by May 8, one month after the beginning of trouble, the wound was almost entirely healed, the patient up and about, and apparently entirely cured.

On Hypospadias.

In the *Journal de Thérapeutique* we find an interesting account of a communication made by Dr. S. DUPLAY to the sitting of the Société de Chirurgie, on January 28, "on the treatment of scrotal and perineal hypospadias." M. Duplay had treated three patients affected with this deformity. Their ages were four, four and a half, and twenty-one. In all, the penis was tightly tied down to the scrotum by a bridle, continuous with the borders of a gutter on the lower aspect of the glans, which is the rudiment of an urethra. The first step in the surgical treatment of the disease is to divide this bridle, and bring the penis up to the belly. The fibrous envelope of the penis is to be freely dissected from the skin of the scrotum, the organ raised and maintained

against the abdomen during the whole time of cicatrization, and for long afterwards. In the case of the young man of twenty-one, two months after the completion of this process sexual intercourse, which was previously impossible, could take place.

A new canal must then be created. This Dr. Duplay only tried on the two older patients; the child of four years having been withdrawn from his treatment. He insists on the necessity of effecting this by gradual processes; and especially on not attempting to unite the new canal to the orifice of the posterior part of the urethra for a considerable time. The meatus, however, may be formed at the same time that the penis is elevated. For this purpose, the borders of the groove are to be pared, and the tissues united over a sound which is left in. Then the new canal is to be formed by dissecting flaps from the under surface of the penis towards the median line, on each side, uniting them in the middle line (of course with their bleeding surface outwards), and then covering them with a flap of skin taken from the neighbouring part of the penis, and raised up sufficiently to glide over the former. This process did not succeed at once in either patient. In the young man, three operations were needed; in the child, four. In fact, it seems doubtful whether it should be done in childhood, children being apt to tear the wound open. The union of the new canal with the old had only been attempted in the man, and then not with complete success. However, only a slight fistula was left, and when he passed urine without raising the penis, the greater part escaped by the new meatus. Whether the semen also passed by the meatus is not specified.

[The result certainly seems better than any which has yet been obtained, and may encourage renewed attempts to cure this distressing malformation.]—*London Med. Record*, October 7, 1874.

—

On Obstruction of the Left Ejaculatory Duct by Concretions from the Vesicula Seminalis (Spermatic Colic).

M. RÉLIQUET relates in the *Gazette des Hôpitaux*, September 3, 1874, the case of a hairdresser, aged thirty-five, married, pale, thin, delicate, and exhausted-looking, who consulted the author on March 12, 1874. For several years he had often suffered, when at stool, from the emission of a small quantity of thick white liquid. For two months he had experienced pain, extending from the anus to the perineum, on emissions during coitus or when emptying the bowels. The erect posture and walking provoked frequent micturition. Attempts to retain his urine caused acute pain and cold sweats. The pain lasted four or five minutes after urination. He lost desire to sleep. Venereal desires and erection provoked pain. During one month and a half he had passed small quantities of blood with his urine.

On March 12, a gum-elastic bougie (French, No. 20) was passed easily into the bladder, but caused excessive pain in the deep part of the urethra. He was sounded for stone the next day, but no foreign body was discovered in the bladder. On examination from the rectum, the left vesicula seminalis was found swollen, hard, and smooth. It was painful on pressure. After the sounding, an attempt was made to pass the bougie once more, but the instrument was arrested at the neck of the bulb, and then withdrawn. After two or three minutes of extremely sharp cutting pains in the penis and the anus, the patient stooped down, and, emptying the bladder, expelled as many as forty small opaque white bodies, about the size of a small pin's head or a lentil. They presented facettes and blunt angles, like prostatic calculi, but their consistence was soft, and they could be crushed between the fingers. To the naked eye, they appeared to be formed of a white homogeneous material devoid of any capsule.

After the passage of these bodies the symptoms quickly subsided, and, on examining from the rectum on the third day, the left seminal vesicle was found of the same size as the right.

On March 27, the man had returned to his usual occupation, and only had to pass urine twice in the night.

Professor Robin, who examined the concretions, sent M. Réliquet the following report: The concretions, opaline, transparent, had a diameter of from one to two millimètres. Their substance, under the microscope, was marked by very fine and very short rectilinear striæ, parallel, closely approximated to each other. Acetic acid caused the striated condition to disappear, and rendered the substance quite translucent, and homogeneous. At the same time it demonstrated numerous spermatozooids rolled together in the concretions formerly marked by the striæ. Where the striation was absent or scarcely marked on the concretions, which were of various forms, such as M. Robin has shown in the vesiculæ seminales of many healthy individuals (Charles Robin, *Leçons sur les Humeurs*, Paris, 1874, 2d edition, p. 443), these bodies had the aspect of normal oves. They had similar reactions to acetic acid, reactions which were not only those of mucus. Their volume was enormous, compared with that of the concretions in normal vesiculæ, and their consistence a little greater. But, they only represented normal corpuscles, which had accidentally attained gigantic proportions, and englobed the spermatozooids in the ordinary way.

Réliquet insists much on these facts in making the diagnosis: 1. That the first pain is produced suddenly at the time of coitus; 2. That subsequently every erection, or even every desire for coitus produces pain. They are, he says, the subjective symptoms. These combined with the objective signs, especially with the uniform swelling of the seminal vesicle, should lead to a correct diagnosis.—*London Med. Record*, September 30, 1874.

—

On Urethro-rectal Fistula following an Abscess of the Prostate.

M. SCHWARZ, interne in the Maison Municipale de Santé, reports (*Union Médicale*, July 2, 1874) the following case, which was under the care of M. Demarquay. The patient, a baker, twenty-two years old, was admitted January 6, 1874. Four months before he had gonorrhœa, and was treated by injections of acetate of lead and diuretic medicines. The discharge lasted fifteen days, and then ceased; the patient had difficulty in passing urine, then retention of urine. A catheter was introduced and retained; he was feverish, had much pain in the perineum, along the urethra, and in the penis. When the catheter was withdrawn, there was a discharge of pus from the meatus. He did not know whether at that time there was matter in his stools; but from that moment every time he passed urine part of it issued from the rectum. In the intervals of micturition no urine escaped *per anum*.

When admitted, he voided as much urine *per rectum* as *per urethram*. The diagnosis was, abscess in the prostate gland opening both into the urethra and rectum, a fistulous passage connecting the two openings. The day after admission an enema was administered, and he was examined with the American speculum. [The reporter is not quite certain what form of speculum is meant by the term "American," as there are several kinds of anal specula used in America; but probably Bozeman's was the one employed.—*Rep.*] There was seen, at the level of the anterior edge of the prostate, an elevation, or papule, in the centre of which was an orifice surrounded by small vegetations; into this orifice a stylet passed obliquely from below upwards, and from before backwards. On passing a metallic sound along the urethra, it could be felt by the probe in the sinus. An injection into the bladder did not pass into the rectum. After the examination, baths and emollient enemata were prescribed, a catheter was kept in the bladder, and the fistulous track was cauterized with tincture of iodine. It was found impossible to retain the catheter, in consequence of the suffering it caused. On the patient passing urine in the presence of the surgeon, it was found that about one-third of the urine issued from the anus; and, on introducing the speculum into the rectum, the urine could be seen trickling from the orifice in the little pimple already described. No benefit resulting from the treatment, the sinus was cauterized with nitrate of silver four times, at intervals of seven, four, and six days. Improvement followed this, less urine passing by the anus; but this amelioration of the symptoms did not continue, and a fortnight later the whole fistulous track was cauterized by

means of a platinum-probe reddened by the galvanic battery. Two strong cauterizations were employed. The patient did not suffer any pain from the operation. A catheter was again introduced; but it could not be kept in. At first the urine passed in much less quantity *per anum*; but when the slough caused by the cautery separated, it again flowed very freely. This only continued for a short time, and gradually the discharge of urine from the rectum diminished, until, thirty-three days after the operation, only about one-eighth of the whole quantity of urine was passed abnormally. Nitrate of silver was re-applied through the speculum to the spot whence pus could be seen to ooze. The result was good; and in a fortnight nearly all the urine passed through the urethra. Three months after, the patient left the hospital; he continued quite well.

M. Schwartz makes the following observations on the case:—

Recto-urethral fistulæ are rare, and they arise from divers causes. Among the most frequent may be mentioned abscess of the prostate; more rarely they may result from abscess of Cowper's glands. These abscesses, the consequence most frequently of blennorrhagia, open into the urethra and into the rectum. The sinus, unceasingly irritated by the foreign matters which pass into it, does not close, and in this manner the fistula arises. This accident, says M. Demarquay, most often follows those cases of gonorrhœa which are treated too heroically at their onset with balsams and injections. In these fistulæ, all the varieties that occur in ordinary perineal fistula may be found; the sinus may be more or less oblique, more or less sinuous, and from the principal sinus other secondary tracks may diverge. The seat is most frequently, as shown by the etiology, the region of the prostate gland; and next, the membranous part of the urethra.

An interesting point in this patient was, that when he had a seminal emission, the fluid all passed by the urethra, and none by the anus; this clearly showed that the urethral fistulous orifice was situated between the openings of the ejaculatory canals and the neck of the bladder.

The diagnosis of urethro-rectal fistula is made from the urine escaping from the anus at the moment of micturition *only*. In the case of vesico-rectal fistula, the flow, so to speak, is continuous. The prognosis, as regards cure, is always unfavourable; because, though the surgeon may frequently succeed in diminishing the calibre of the sinus, he very rarely succeeds in obliterating it completely. Under any circumstances, and whatever treatment may be adopted, the fistula fills up and heals, but very slowly. Among the most important methods of treatment may be mentioned, cauterizations with the hot iron, divers caustics, injections, tincture of iodine, and, in some cases, section of the track.—*London Med. Record*, Aug. 12.

—
On Tuberculosis Ulceration of the Anus and of the left Buttock in a patient suffering from Pulmonary Phthisis and Tuberculous Ulceration of the Fauces.

M. MARTINEAU exhibited to the Société Médicale des Hôpitaux (*L'Union Médicale*, July, 1874) a model representing a tuberculous ulceration of the left half of the anus and the corresponding buttock.

The patient stated that the ulcer had been preceded early last April by an itching pimple; soon numerous pimples developed, and the itching became very severe; to this itching there followed a sharp persistent pain, increased by the passage of feces—which since the month of March had been liquid. At the beginning of May he was seen by Dr. Martineau, who thus minutely describes the character and condition of the ulceration. On the left buttock was an ulcer irregularly round, having its point of commencement in the rectum on the left side of the intestine, and extending to the upper border of the sphincter. The edges which limited the ulceration on the buttock were slightly projecting, not cleanly cut, and gradually merged themselves in the centre of the ulcer. The margin of the ulceration was slightly bluish in colour, and presented numerous nipple-shaped projections, or multiple yellowish granulations, about the size of

a pin's head. Some of these granulations were in process of destruction; they were replaced by an ulceration which, gradually extending itself superficially and deeply, became mingled with the central portion of the ulcer, which was gray and not bloody; it presented also numerous nipple-shaped projections, yellowish, and separated one from the other by alveoli, giving the ulceration the aspect of areolar tissue, and also by fissures, notably two which, starting from the circumference, were prolonged into the interior of the rectum, extending to the upper part of the sphincter. The antero-posterior diameter of the ulceration measured about $1\frac{1}{2}$ inches, and from without to within it was about $2\frac{3}{4}$ inches. The ulceration appeared to affect only the skin and superficial parts of the dermis. The ulcer itself was soft and pliable, and had no hardened basis. Around the ulceration on the left buttock, in the sulcus, and on the right buttock, there were eight or ten prominent tubercles, which were not painful. (Two of these tubercles had recently commenced to break down.) The external glands in the groin were slightly tumefied, but not painful.

Dr. Martineau considered that the tuberculous nature of the ulceration could not be doubted. It resembled exactly the tuberculous ulceration of the tongue described by Dr. Féréol. There was not the slightest evidence of syphilis in the patient. If anything were wanted to set the question at rest, it might be found in the fact that the patient had all the physical characteristics of pulmonary phthisis. He had constant cough, great emaciation, diarrhœa, is aphonic, had tubercular ulceration of the fauces, and in all probability of the larynx also. No treatment had availed to arrest the ulcerative process, but the pain was much relieved by the use of a lotion composed of one part chloral hydrate to one hundred of water.

In the discussion which followed, Dr. Féréol agreed with the author in his diagnosis. He had seen several precisely similar cases, and cited two as having occurred last year at the Maison de Santé, and another at the Hôpital St. Antoine.

[Mr. WM. ALLINGHAM has observed ulceration of the rectum, anus, and adjacent parts, to which the description of Dr. Martineau would most accurately apply; but he has never seen in association "tubercles" developed in the buttocks or elsewhere in the neighbourhood of the ulcer, nor the question as to the tuberculous origin of the ulceration so decidedly and unmistakably answered.]—*London Medical Record*, Sept. 23, 1874.

On Subcutaneous Fracture of Exostosis of the Femur.

In the *Edinburgh Medical Journal* for July, Dr. CHIENE, *à propos* of a case under his own care, asks the question, "Is an exostosis, after it is broken off by violence, ever absorbed?" A boy, aged fourteen, was brought to Dr. Chiene, in April, 1873, with a hard, movable tumour under the muscles of the thigh, above the inner condyle of the right femur; with a history that it was first known to him twelve months previously, when, after recovery from a blow on the inner side of the knee, which had caused swelling and pain, and some inability to bend the joint, he found a hard lump, which he could move backwards and forwards. When he was first seen by Dr. Chiene, there was an irregular osseous mass, freely movable, of the size and shape of a walnut, under the vastus internus, two inches above the condyle. When moved, it rubbed against an osseous surface on the femur, but the feeling of crepitus, although perfectly distinct, was somewhat modified, as if the opposing surfaces were covered by fibro-cartilaginous material. Soreness after violent exercise or free manipulation of the tumour was the only thing complained of; and Dr. Chiene recommended delay before the removal of the detached exostosis, in the hope that its absorption might follow the cutting off of its principal blood-supply. From this date the tumour gradually lessened; in October the boy could feel nothing; and in April of the present year, with the exception of a slight linear projection an inch in length, on the osseous ridge, leading up from and about two inches above the internal condyle, Dr. Chiene could not distinguish any difference between the limbs. The result of this case suggests to Dr. Chiene the

advisability, in the treatment of exostosis, of attempting in the first place to break off the exostosis subcutaneously, by laying hold of it with large forceps, well padded so as to prevent injury of the skin, in the hope that absorption of the tumour will take place in consequence of the loss of blood-supply; and, secondly, that in such a case as his own the surgeon should wait, and not hastily cut down on the tumour to remove it.

The August number of the same journal contains a preliminary notice from Mr. MAUNDER, of a similar case under his care in the London Hospital. He had in June discussed the possible methods of treatment—subcutaneous fracture, subcutaneous section by chisel and mallet, and by free incision; and on July 8 he was able, under chloroform, to determine that the globular head of the growth was attached by a slender stem to the outside and back of the femur near to the knee-joint. This pedicle was fractured with comparative ease with a large pair of pliers, and with a jerk, the skin being protected with a piece of chamois leather. Some swelling and ecchymosis followed this operation, the result of which is not yet made known.

[Subcutaneous absorption must be a much preferable and infinitely safer method for the removal of exostosis, than that by free incision, an operation bordering often closely on the knee-joint. Accidental fracture of the stem of an exostosis of the femur, when the stem is slender, is not unknown; and it would be well in all such cases to adopt the suggestion of Dr. Chiene, and defer operating, with the hope of ultimate absorption of the tumour. We shall be interested to know the end of Mr. Maunder's case of artificial detachment of the exostosis.]—*London Medical Record*, Oct. 21, 1874.

— On Three Remarkable Cases of Dislocation.

M. D. MOLLIÈRE, of the Hôtel-Dieu, in Lyons, relates (*Lyon Médical*, No. 14) the following cases:—

Case 1. *Complete Luxation of the Left Elbow-joint outwards; Reduction.*—This occurred in an idiot, aged forty. The region of the left elbow was swollen, painful, and presented the following appearances: (1) The forearm was flexed upon the arm at an obtuse angle; (2) there was a considerable enlargement of the elbow transversely; (3) the capitellum of the radius was plainly seen beneath the skin, externally; (4) the ulna was not plainly felt, owing to its being hidden by the prominence of the radius; (5) internally was a well-marked eminence, formed by the articular extremity of the humerus, which was readily felt, beneath the integument, in all detail. The anterior aspect of the humerus looked directly *inwards*. Reduction was made, without an anæsthetic, by direct traction and flexion. The bone had been dislocated for three days. The excessive rarity of this accident renders it worthy of record. Nélaton reports one case only in his *Pathologie Externe*.

Case 2. *Dislocation of the Right Femur on to the Dorsum Ilii, of fifty days' standing. Reduction by Pouteau's Method.*—A man, aged sixty, fell from a tree, and dislocated the head of the thigh-bone on to the dorsum ilii. On presenting himself at the Hôtel-Dieu, all inflammatory symptoms had disappeared, and the amount of shortening was rendered appreciable by Giraud-Teulon's method of triangles, thus—

	Sound side.	Injured side.
From the anterior superior iliac spine to the ischium	18.50	18.50
From the anterior superior iliac spine to the external condyle of the femur	47.50	44.50
From the ischium to the external condyle of the femur	40.50	40

Chloroform being administered, Pouteau's method was first tried without success; and, on breaking up the adhesions, direct traction was tried, and failed, and so also did Jarvis' apparatus as modified by Matthieu, both with the limb flexed and extended. A last attempt, however, by Pouteau's method, succeeded, an assistant's hand being placed between the front trochanter and a solid *point d'appui* placed immediately behind it. M. Mollière employed

flexion, rotation, and then abduction, and employed considerable force in this latter movement, using a lever, having as its power the shaft of the femur, its fulcrum the trochanter, and weight, the head of the femur. The distinct presence of the head of the femur lying amongst the soft parts, and the inguinal depression being clearly marked, convinced M. Mollière that he might reasonably employ such severe measures for so considerable a time, notwithstanding the patient's age, since the obstacle lay exclusively among the soft parts, and there was no malformation.

Case 3. Compound Fracture of the Right Tibia and Fibula; Dislocation on the Dorsum Ilii, with severe Contusion of the Trochanteric Region; Injury to the Face; Cerebral and Spinal Complications; Reduction by Pouteau's Method; Recovery.—The patient was a boy, aged fourteen, who fell from a building. On admission his symptoms were so serious that M. Mollière, believing death imminent, applied a silica bandage, with the view of alleviating his suffering, without further examination, and placed the limb on a Bonnet's splint. He improved by degrees, and, on an examination made on the sixteenth day, a complete dislocation into the dorsum ilii was detected. Ether was administered, and an assistant instructed to follow the movements of M. Mollière by sustaining the fractured limb, which was enveloped in its apparatus. The process of reduction was commenced, and it was decided not to prolong it for fear of breaking up the uniting fracture, so the assistant placed his hand behind the trochanter, whilst M. Mollière made the flexion, rotation, and forced abduction. The bone entered the cotyloid cavity immediately.—*London Med. Record*, Aug. 26, 1874.

Dislocation of the Head of the Femur into the Great Ischiatic Notch; Fracture of Neck following attempted Reduction at the end of nine weeks.

Dr. DAWSON (*Clinic*, Oct. 17, 1874), at a recent meeting of the Cincinnati Academy of Medicine, presented the following report of the case of Capt. W., of middle age, who was badly burned by a steamboat boiler explosion, and at the same time suffered dislocation of the hip into the great ischiatic notch.

"I placed the patient under the influence of ether, and instituted a rotating motion to break up any attachments which the head of the bone had made during its sojourn in its new situation, then I resorted to the ordinary plan of reducing by manipulation. In this, for the first two or three efforts, I followed the advice of our distinguished countryman, Prof. Frank Hastings Hamilton. I allowed the limb to 'follow its own inclination.' Then more force was used, the thigh was pressed forcibly across the abdomen, acting thus as a lever, the head of the bone would be lifted from its new position, so that by a rapid circumduction I expected to throw the head into its proper place.

"At the sixth of these efforts of forcible flexion, adduction, abduction, and circumduction, the neck of the bone suddenly snapped. The sound and the impulse imparted to my hands were very different from those which are experienced when the wandering head drops into the acetabulum. The whole aspect of the case was at once changed. The symptoms of fracture of the neck within the capsule were all painfully manifest. The limb was shortened more than one inch, the foot was everted, preternatural mobility was present, and crepitus distinct. Syme's test disappeared, the head of the bone could still be felt through the rectum, but it ceased to move under the end of the finger when the leg was rotated.

"Fracture of this bone has followed attempts at reduction by all plans, extension, 'lifting method,' and manipulation. Prof. Hamilton refers to a number of these unfortunate cases in his work on Fractures and Dislocations. Dr. Jas. R. Wood, at Bellevue Hospital, in 1865, fractured the neck when forcibly abducting; his patient was sixty years of age, and the dislocation of five months' standing. Dr. David Prince, of Illinois, has had a similar experience. Dr. Markoe reports a case where the neck was broken 'after manipulation had been employed, but while extension was being made by the hands united with a lifting outwards.' Dr. Bigelow, who has written so learnedly and so instruc-

tively upon dislocations of the hip, once fractured the neck of the thigh by 'flexing the limb once slowly upon the abdomen, a movement which was attended with a continued fine crepitation about the hip.' Prof. H. gives five cases in which the bone was broken in efforts at reduction by extension, it occurred with Travers, Malgaigne, Physic, Randolph, and Gwyne.

"After some reflection, and from my limited experience, I can hardly escape the conclusion that in most of the cases in which fracture occurs under extension or manipulation, the bone was evidently diseased. In my own case, although at the time I was making abduction and circumduction, I certainly did not exert force enough to fracture a healthy bone. The case which Dr. Bigelow reports would seem to be one of fragilitas ossium. In Malgaigne's patient the thigh broke at its lower third and that too by extension!"

—

*A Rare Form of a Congenital Cystic Fibroma Molluscum of the Elbow;
Removal by Operation; Successful Result.*

DR. CHARLES B. BRIGHAM, of San Francisco, reports (*Western Lancet*, Sept. 1874) the following case of this: J. W., æt. 5 years. The patient was born with a tumour on the left arm, situated over and just below the elbow-joint, on the inner and posterior part of the limb. At birth this tumour was about the size of a hen's egg, soft, and marked at the most prominent parts of its surface with a delicate, nævus-like congestion of the superficial vessels, slightly raised, and giving the skin in that part, a dark-violet appearance; there were also hairs of perceptible length, growing amid the congested vessels. The tumour remained about the same size during the first two years, but in the third year it began to increase, and now it has reached a size given below (4 inches in length by 7 in circumference); it presents to the eye the same general appearance as at birth, only it is larger and more lobulated—its limits are tolerably well defined; the skin over it is somewhat lax and natural in appearance, except at the discoloured portion, which now measures 2 inches by 3, and has many hairs upon it, half an inch in length. To the touch, the tumour is lobulated and very soft, with no pulsation whatever, but with a distinct fluctuation in certain parts. The lobe nearest the wrist appears almost detached from the main tumour, and it is in the direction of this lobe that the tumour increases, burrowing, as it were, under the skin. The tumour is adherent, to a certain degree, and when pressed laterally between the fingers, it gives a sensation as if there were a hard substance in its centre; this hardness was afterwards shown to be due to the dense fibrous stroma of the tumour. The patient has no other tumours or spots on his body; he had repeated falls upon the arm, making the tumour "black and blue," and it was a severe bruise that at last influenced the father of the child in favor of an operation. It was explained to him that the tumour was situated between the skin and the muscles, that it probably had no connection with any large vessels; that its contents were serum, and not blood, as he had supposed; that the elbow-joint was as yet unaffected, and that if the tumour were removed, the motion in the joint would be in no wise impaired. Thus assured, he consented to its removal, and indeed expressed his desire to have had the operation done ever since the birth of the child. On the 6th of August, Dr. G. J. Vanvlack assisting, the patient was anæsthetized. Ethyl was used at first, and in less than two minutes, the patient was completely insensible; ether was then substituted, and continued throughout the operation. An elliptical incision, three inches in length, was made on either side of the discoloured portion of skin; both flaps were then carefully dissected up, so as not to open the cysts in the operation. On the outer side, the tumour was covered by a thin layer of skin, with little, if any, fat; a fact which led to the supposition that the tumour began its existence from that side; and also very early in uterine life, when there was but mucous tissue beneath the skin. On the inner and lower sides, the tumour was enveloped in fat, three or four small vessels were temporarily compressed; no artery of any size was seen; the hemorrhage, which was slight, was mainly venous; the tumour lay on the muscular aponeurosis, attached at two points;

the subjacent muscles were much flattened by the pressure from the tumour; the sides of the incision were brought together by fourteen sutures, and the wound was then dressed with Lister's dressing.

The tumour measured 4 inches in length by 7 in circumference; it was made up of cysts and fibrous stroma, the cysts being the hypertrophied areolar spaces of the connective tissue, while the stroma represented the dividing septa. There were three large cysts, side by side, much the size and shape of a testicle, and many smaller ones, from the size of a pea upwards. The contents of two opened cysts were as follows: the one of clear amber-coloured serum; the other, and larger one, of bloody thickish serum (doubtless not the original colour of the cyst contents, but resulting from an effusion of blood caused by the severe fall upon the tumour). The inner walls of the opened cysts strikingly resembled those of a ventricle of the heart, there being a surrounding network of trabeculae. There was no point of connection between the cysts; there were no arteries of appreciable size connected with the tumour; microscopic examination showed a tissue made up of curled white fibres; the tumour weighed four ounces.

The sutures were removed from the wound on the 9th, the strips of court plaster substituted; there was no swelling of the arm or hand. The wound was again dressed on the 12th; its lips had slightly separated, but were firmly adherent to the subjacent tissue. The patient suffered no pain; the wound was just cicatrizing, when, on the 19th, a slight redness was observed near the wrist; there was no swelling, but considerable pain; the whole arm was then enveloped in a flaxseed poultice; the redness extended to one side of the wound; a slight swelling near the upper end of the incision was lanced, and gave exit to a few drops of pus. In a few days the redness subsided; the arm was bathed daily in warm soapsuds; the poultices were continued up to Sept. 4th, when the wound was wholly cicatrized; the arm has perfect movements.

On the Treatment of Hygromata containing False Cartilages.

At the recent congress of the German Society of Surgery (proceedings reported in *Berliner Klinische Wochenschrift*, No. 35, 1874), Professor VOLKMANN stated the results of his experience as to the use of drainage in cases of hygroma with floating contents. In three cases of this kind treated in the preceding twelve months, an incision three-quarters of an inch in length was made into the sac at its upper, and another similar incision at its lower extremity; the free contents of the sac were then extruded, and the bodies adherent to its inner surface rubbed off by pulling backwards and forwards through the cavity a tightly stretched drainage-tube. This tube was then left in the sac, and the seat of the operation covered by Lister's dressing. In all three cases obliteration of the sac resulted, without any intercurrent disturbance or the slightest local reaction. He did not observe phlegmon, diffused suppuration, or necrosis of tendon, and the mobility of the fingers remained unimpaired. The removed floating cartilages were found to be concretions formed of coagulated albuminates, and were not organized growths. The name, therefore, of hygroma proliferum is not well adapted to these growths. In one case, where a portion of the cyst-wall was excised and examined, the inner surface was found to be coated by a thick layer of coagulum, which was rough, and studded by tufts projecting into the cavity of the hygroma. Volkmann has also observed along the threads of a seton introduced into an hygroma a thick layer of coagulated albuminates, and at the free extremities of the thread firm club-shaped appendages of the same material.—*Lond. Med. Record*, Nov. 4, 1874.

Case of Spina Bifida (Dorsal) cured by Injection.

DR. JAMES MORTON (Surgeon to the Glasgow Royal Infirmary), on two former occasions, recorded in the *British Medical Journal* two cases of spina bifida in the lumbar region, both cured by injecting the iodo-glycerine solution, which

he employs; and subsequently Dr. Watt, of Ayr, narrated two cases treated by the same method and the same liquid, and terminating equally happily.

Dr Morton now records in the same journal (Oct. 24, 1874) an equally fortunate result in the case of a child presenting a similar deformity in the upper dorsal region. The following are the notes of the case:—

"On June 22d, Dr. Thomas Smith asked me to see a case of spina bifida with him. The patient, a little girl named Christina Morrison, aged seven weeks, was rather delicate, and did not seem to be thriving as well as the mother could wish. The tumour, which was present when the child was born, was globular in shape, about the size of a peach, not pedunculated, elastic, and semitransparent. It was situated rather high up, being immediately over the seventh cervical and first dorsal vertebrae, and, as a consequence, greater care was required in its treatment. It was said to have burst, and a quantity of a clear fluid to have escaped. The opening seems to have closed; and, the fluid reaccumulating, the swelling became larger than ever. Some time before the case was brought under my notice, the child was presented in the wards of a large surgical hospital, but nothing was attempted in the way of cure or treatment.

"June 23d. The tumour was tapped by means of a fine trocar and canula, and a quantity of fluid drawn off. At this tapping, a small quantity of the iodo-glycerine solution was injected, and the puncture carefully closed by means of collodion. Besides a little paleness, no appearance of shock was manifested, the child speedily taking the breast. Towards evening the child became restless, and did not sleep during the night. It cried occasionally. As the morning wore on, it became calmer, and then had a very refreshing sleep. The fluid again accumulated, showing that the injection had not fully answered my purpose.

"On July 3d, the tapping and injection were repeated. This time no effect was produced upon the child. It took the breast, and slept soundly and well, and, in fact, behaved as if nothing had happened more than usual. A good deal of serum and blood escaped after the injection, and it was with much difficulty that I could get the puncture closed. This I ultimately managed by means of a piece of cotton rag soaked in collodion.

"July 25th. The child was visited to-day, and the mother said that ever since the last operation the child had done well; the tumour gradually diminished in size, and the health of the child was greatly improved. It has complete power over its limbs, and seemed to delight in using them. The mother remarked that the 'bairn' never enjoyed such good health. The tumour was about the size of a large strawberry, and of a light purplish colour. It was quite solid. The surface was irregular and puckered up something like a child's scrotum which had been exposed to the cold, or rather like a bulky raisin. On August 18th the child continued well.

"This case, and the other four to which allusion has been made, are the only cases which have been subjected to this mode of treatment, and all have proved fortunate. Though the cases are still few, the uniformly successful results are most encouraging, and may induce others to try to increase the number of cures. Success in every instance it would, I fear, be Utopian to expect; but if success become the rule and failure the exception, this mode of procedure may be held to be the safest hitherto made known in the management of such a dangerous congenital malformation."

Traumatic Facial Neuralgia; Excision of a Portion of the Inferior Dental Nerve and of the Infra-orbital Nerve; Complete Relief.

Dr. CHARLES B. BRIGHAM, of San Francisco, reports (*Western Lancet*, August, 1874) the case of C. P. C., male, æt. 55, who, eight years ago, was struck in the face with a chair, it splitting the nose down to the right cheek. A month afterwards the wound was healed, leaving a cicatrice $1\frac{3}{4}$ inches in length. Two years later the patient felt a tingling in front of the ear, and along the roots of the teeth of the upper jaw. There was a crawling pain and

uneasiness, at times coming in flashes, as if many needles were pricking the cheek: it seemed to go from tooth to tooth. In the course of the five subsequent years, eleven sound teeth were extracted in hopes of relief. The pain then concentrated itself under the right ala of the nose, beneath the cicatricial tissue, upon which, should any one press, ever so slightly, a pain would start up all over the right side of the face—at last the pain extended over the entire side of the face up to the forehead. Momentary or continued pressure on the supra-orbital nerve, or on the eyeball, aggravated it so much that the tears would flow afterwards. As a general rule, whenever the patient swallowed either food or drink, the pain was agonizing; if he passed his tongue over the lips it felt like a hot coal burning him; if he pressed his lips together the pain, as he expressed it, was “tremendous.” Even the act of speaking was attended with pain, coming on by fits and starts. At night the simple moving the head, so that the pillow pressed on the cheek, would wake the patient up five or six times. On account of the continuous pain, morphia had been given subcutaneously to the amount of 6 grains every twenty-four hours. The interruption of sleep, the difficulty experienced in taking food, and the almost constant pain (there being about thirty spasms a minute) had reduced the patient to a very low condition. The various local and general means of treating neuralgia had been resorted to in this case without result. Finally, the patient resolved to try the chances of a surgical operation. It was decided to excise as large a portion as practicable of the infra-orbital nerve, and also, as there was great pain in the lower jaw and lip, excision of a part of the inferior dental nerve was thought necessary. On the 25th of July, Dr. D. J. Vanvlack assisting, the patient being etherized, an incision, slightly concave towards the angle of the mouth, and measuring exactly two inches in length, was made on a line extending from a little below the coronoid process to the angle of the jaw. The fibres of the masseter muscle were exposed and separated in the line of the incision by means of a director. The periosteum was removed by means of a scraper as far as was necessary, in order to admit the crown of the trephine. Small retractors held the muscle and skin out of the way of the saw as it passed through the plate of the bone—the disk being elevated and removed, the nerve was immediately exposed, and by means of a small blunt tenaculum was separated from its neighbouring vessels; it was then cut with a pair of scissors. It had nothing abnormal in its external appearance. The disk of bone removed bore the imprint of the dental canal, running along at the side of the hole made by the centre-pin of the trephine: one small, cutaneous vessel was tied. Leaving a dry sponge in the wound, a triangular flap of skin was then dissected up from under the right eye, the base of the flap being the infra-orbital ridge, while the apex pointed to the ala of the nose; three large branches ($\frac{3}{4}$ of an inch in length) of the infra-orbital nerve were excised; eight small vessels were ligated, four silk sutures united the edges of the wound, leaving the ligatures to come out at the inferior angle. Three sutures were then placed in the lower wound, and two damp sponges were placed over each line of incision, and the whole side of the face was dressed with carbolized glycerine (1 to 10) —Lister's gauze and cotton-wool—an injection of brandy was given per rectum during the operation; a subcutaneous injection of $\frac{1}{2}$ grain of morphia was given directly afterwards. The pulse before the operation was 120; in the evening afterwards was 80, T. 100; skin moist. The patient has had two naps in the afternoon; when he drinks, he fancies that the tumbler has a bit broken out of it; his wife has not seen him so comfortable for years. He himself says that he has had two slight flashes of pain. It is questionable whether this comes from the old trouble, or whether it is not a sensation similar to that which a person feels after a painful limb has been amputated; or again from the irritation of the proximal part of the nerve caused by the operation of excision. July 26th, slept well all night; for many years he has not been able to drink more than a swallow at a time; now he drinks when he pleases without pain; he feels more soreness on the left side of the jaw than on the operated side; has had a few twinges of pain in the upper lip; says he should not have noticed them if he had not had them before. P. 82, T. 102. July 30th, the lower jaw wound has healed by primary union. Nose and right cheek attacked

with erysipelas, which by the 4th of August had faded away, and on the 15th the patient walked out of doors. On August 22d, it is noted that the patient has no pain whatever, no paralysis of the face; eats well, passes excellent nights, and is on the way to speedy recovery.

—

Neuralgia of the Lower Jaw and Tongue treated by Excision of the Nerve.

Dr. THEO. A. MCGRAW, of Detroit, reports (*Detroit Review of Medicine and Pharmacy*, Sept. 1874) the case of Mr. H., of Faribault, Iowa, who had suffered for several years from a neuralgia of the left side of the tongue and lower jaw, which was becoming more and more constant and severe. The agony was so great that he was at times prevented from talking or eating. He had tried every remedy of which he had heard, and came to Ann Arbor, in the winter of 1871-72, to have the nerves leading to the painful areas excised. I saw him first in January, 1872. I examined him carefully, to find, if possible, a cause for his terrible suffering. The teeth had been for the most part already extracted, and the gums seemed sound and natural. Careful investigation failed to reveal any eccentric cause of irritation, and I finally yielded to his desire, and operated upon him, in the hope that the disease might have its seat in the terminal nervous filaments. I performed the operation in the presence of the medical class, and by the assistance of Dr. Frothingham, on the third of February, 1872. I cut down upon the ramus of the lower jaw, splitting the masseter muscle and pushing its fibres aside. I then trephined the bone at the point where the inferior dental canal begins, and excised through the opening about half an inch of the inferior dental and gustatory nerves. The patient did well and recovered.

"I wrote to him a few weeks since to inquire as to the final result, and learned that he had remained free from pain for fourteen months. In April of 1873 it began to return, and now he describes it as bad as ever."

Dr. McGraw, in reviewing this case, says, "it is evident that the seat of the neuralgia is in this case somewhere in the peripheral nervous filaments, although no disease of the tongue or jaw could be discovered by the eye or touch. The recurrence of the pain in April, 1873, would indicate that a regeneration of the nervous tissue had taken place at that time, and that the nerves had then begun to resume their functions. I have advised the patient to have a tenotome passed through the jaw at the spot where it was trephined, and have the nerves re-divided. It would seem as if some process by which the nervous regeneration could be prevented in these cases ought to cure neuralgias of this description."

"I have been pleased with a suggestion of Dr. W. H. Stevens, of Faribault, respecting neuralgias confined to the jaw alone. The doctor suggests that the dental canal be plugged with gold after the division of the nerve, thus making its regeneration impossible."

Midwifery and Gynæcology.

On a Case of Twins at the Eighth Month, with a Peculiar Ring-shaped Low Situation of the Placenta, without Hemorrhage.

Professor ALOIS VALENTA, of Laibach, reports in Betz's *Memorabilien* (vol. xix. part v. 1874) the case of a primipara, aged twenty-eight, who came under his care on November 13, 1871. The case was made out to be one of twins. Pregnancy had been prematurely interfered with at the eighth month, by a severe spasmodic cough, aided by the irritability arising from the great distension; and the patient had pains in the loins indicative of parturition. A head and a breech presented. Distinct labour-pains set in on November 19; but, as little progress

had been made at noon the next day, the membranes were ruptured by means of an elastic catheter, and delivery completed. The breech case was delivered first; one child weighed three pounds, and measured fifteen and three-quarter inches long; the other weighed two and three-quarter pounds, and was fifteen and a half inches long. They were considered to be eight months' children, although the mother menstruated last on June 24. The infants died on the third day. There was some *post-partum* hemorrhage, which was arrested by the injection of ergot *per rectum*, and the woman was discharged on December 9th. The placenta was especially noteworthy. There were two after-births, two amnion, and two chorion. They were so connected one with another that to judge from the rent in the membranes, their lower borders closely surrounded the internal os, forming a ring about five or six inches broad. The lower part of the ring corresponded to a rupture of the membranes, which was performed artificially in one only of the sacs, and was about six and a half inches in the transverse diameter. The four membranes formed a septum, dividing it into two nearly equal parts. The diameter measured five and a half inches. The average diameter of the ring, at its upper part, was eight and a half inches. The two ova were inclosed, as it were, by a belt formed of the two placentæ, which accounted for the rather unusual occurrence of being able at first to distinguish the presentation of each fœtus with equal facility. There was no hemorrhage, although the placental sites were so low.—*Lond. Med. Record*, Oct. 14, 1874.

On Bifid Vagina as a Cause of Impediment to Delivery.

Dr. VALENTA, of Laibach, relates in Betz's *Memorabilien*, vol. xix. part 5, the case of a primipara, aged twenty-six, who entered the clinique in labour; on examination, the os was found dilated about the size of a crown, the vagina still firm, and the membranes ruptured. On repeating the examination later on, the vagina felt narrower, and the os so small as to be incapable of admitting the tip of the finger. A closer investigation to account for this strange phenomenon disclosed a "vagina duplex."

The septum was very vascular, about four lines thick, and of a structure precisely similar to the vaginal walls: it passed from the surface of the urethra directly backwards, dividing the vagina into two nearly equal parts, the right being the smaller. The finger could be hooked over its upper margin, which was in close proximity with the os, and a finger introduced into the opposite vagina could be made to meet the other above the septum. By means of spatulas, the foetal head could be seen pressing down on the septum with each pain. It was divided with the blunt-pointed scissors, care being taken to make the incision nearer to the posterior vaginal wall than to the anterior. There was considerable hemorrhage from the anterior flap, which was ligatured. The head came rapidly down, completely arresting further hemorrhage. Not a drop of blood came away after delivery. The ligature was removed on the third day for fear of causing a slough. The woman did perfectly well. Strange to say, on examining the vagina some short time afterwards, the anterior flap was entirely gone, and not a trace was left to show that such a condition had ever existed, whereas the posterior flap formed a firm prominent ridge. The uterus was normal.—*London Med. Record*, Oct. 14, 1874.

On Prolapse of the Umbilical Cord.

Dr. GEO. ENGELMANN, of St. Louis, contributes to the *American Journal of Obstetrics*, August 4, 1874, a paper on this subject. He says that the causes of prolapse of the umbilical cord have mainly proved to be such circumstances as prevent the complete filling of the pelvic brim, and the close adaptation of the lower segment of the uterus to the presenting part. One of the more important of these circumstances is the shape of the foetal part itself, and thus foot-presentations are more frequently complicated by prolapse, whereas vertex presentations are least threatened. The foetal appendages are of secondary and minor importance; undue length of the cord, its marginal insertion or

attachment of the placenta low down in the uterus, can never be direct causes of the accident; excess of liquor amnii is alone to be feared.

Some stress is to be laid on abnormality in shape and position of the womb, much more upon twin-births. More dangerous than any of these is the contracted pelvis, which Dr. Engelmann proved by measurements and numbers to be the main cause of prolapse of the funis, directly and indirectly. Primiparæ are, comparatively speaking, almost as frequently afflicted as multiparæ.

The *post-mortem* examinations revealed only the lesions due to death from asphyxia, nothing characteristic for death caused by prolapse of the cord.

The prognosis is somewhat better than generally allowed; most favourable for foot presentations, while vertex presentations are more dangerous than any; the case being, under all circumstances, more threatening when occurring in a primipara.

In the treatment the postural method is important, more as an adjuvant, however, than as a method in itself of dealing with the prolapse.

Version is comparatively the most successful of all operations, and should be more frequently resorted to when any choice of method is given, as in head presentations; the application of the forceps and reposition of the cord are less to be relied upon; but, whatever may be the course determined upon, it must be borne in mind that the success of all operations by which we seek the preservation of the child whose life is threatened by compression of the prolapsed cord is in a measure dependent upon the judicious use of chloroform, and its application to full surgical anæsthesia.—*London Med. Record*, Oct. 28, 1874.

On Bleeding to Death of the Fœtus during Parturition.

Dr. VALENTA, of Laibach, relates, in Betz's *Memorabilien*, vol. xix. part 5, a case in which bleeding to death of the fœtus took place during parturition, through a rent in the umbilical vessels, which crossed transversely over the os.

A woman was delivered of her second child at full time. The mother stated that before the labour-pains began the waters ruptured, and from that time, up to the completion of the labour, which was of ten hours' duration, she had a continuous discharge of blood. At no time, however, was the stream observed by the attendants to be of a pumping character. On examining the after-birth, it was found to be about six inches in diameter, situated high up *in utero*. The umbilical vessels were given off from its lower margin, and before uniting to form the cord they ramified in the surface of the chorion for about four and a half inches. The cord measured sixteen and a half inches. There were four veins passing from the placenta, which soon united to form two venous trunks, one of which, the smaller, arched outwards before uniting with its fellow to form one umbilical vein.

At the point of junction, and at a slight distance from it, were two rents. The two arteries united to form one trunk on piercing the chorion, which immediately gave off a small branch that coursed along with the above-mentioned smaller vein. This was also torn across.

This case clearly shows the necessity of carefully examining the placenta of any woman where death of the fœtus has occurred.—*London Med. Record*, Oct. 14, 1874.

On a Case of Extrauterine Pregnancy.

Dr. LUDWIG BANDL reports in the *Wiener Medizinische Wochenschrift*, of August 8, a case of extrauterine fœtation occurring in the practice of Professor Karl Braun-Fernwald, in which rupture of the ovum took place at an early period of pregnancy, and the embryo arrived at full maturity in the cavity of the abdomen.

According to Hecker and Cauwenberghe, ovarian and tubular pregnancies generally terminate fatally both to mother and fœtus about the third or fourth month, through rupture of the ovum. In abdominal pregnancy (extrauterine) this accident often does not occur until towards the end of gestation. The

fœtus generally dies forthwith, and it is only in very rare instances that the ovum develops and lives in the abdominal cavity (*graviditas extrauterina secundaria*). Most gynæcologists are incredulous of this form of fœtation. Schröder says that there is no doubt that a fœtus in this condition, as it becomes encapsuled by new inflammatory exudations, can live but for a short time. Only one similar published case to that now reported has been found by the author (Walter, *Monatsschrift für Geburtskunde*, vol. xviii.). The present one occurred in a woman aged thirty-five, mother of two children. Each previous confinement was natural. She was admitted on Nov. 20, 1871, into the hospital in a wretched condition. She menstruated last at the beginning of April. During the first two months of gestation she was quite well; since then she had been in continual pain, and had become greatly emaciated. On admission the abdomen was distended, resonant over its whole surface, with distinct fluctuation. The fœtus could be easily made out, and its heart-sounds heard. *Per vaginam*, the os was found to be as high as the arch of the pubes, and was only reached with difficulty. It was soft and patulous, admitting two phalanges of the forefinger. The fœtus could not be felt; but by bimanual examination the body of the uterus was made out to lie in the left side, and in the right iliac fossa, and stretching in the pelvic cavity an elastic swelling. Extrauterine fœtation was diagnosed. The uterine sound was used three days afterwards, and passed four inches to the left. With a delicate movement of the sound towards the right, it was made to pass nine inches, and its point could be easily felt beneath the thin abdominal walls in the neighbourhood of the umbilicus. This passage of the sound made the diagnosis of extrauterine fœtation somewhat doubtful. The sound had either passed into the gravid uterus or into the dilated cavity of a uterus bicornis or duplex, or there might be an intrauterine pregnancy along with the extrauterine. Perhaps the uterus had been perforated or the sound had slipped up the Fallopian tube. Although Matthews Duncan, Veil, and Hildebrand maintain the possibility of the uterine sound passing into the Fallopian tube, still, judging from experiments on the dead body, Dr. Bandl thinks it scarcely credible. He believes with König, that in all these instances there has really been perforation of the uterine walls. The puerperal uterus is readily perforated by a slight pressure of the sound; and that organ in extrauterine fœtation is in a similar condition. The writer states that he has in several cases perforated the uterus in the dead subject with the sound without using any force, in women who have died during the puerperal state. Alt's experience is the same. Martin reports a case where, some months after parturition, on laying open the abdomen, the point of the sound was found sticking through the walls of the uterus. In the above case it was, therefore, very probable that the instrument had perforated the uterus.

On November 29 Professor Braum held a consultation with Professor Späth and Professor G. Braun on the case. The sound had failed to give any assistance in ascertaining the nature of the swelling lying to the right in the abdomen; nor did it exclude the idea of a uterine pregnancy, or of a fœtus in the right half of a uterus duplex. The body felt in the right iliac region might be either the placenta, a tumour, or an ovarian cyst. The woman having been anæsthetized, the sound again passed the ten inches in the same direction as before. With the hand in the vagina, the forefinger could be passed easily inside the uterus, and the fundus could be easily pressed down from without on the finger. Nowhere could any opening be felt indicating a double uterus. The swelling on the right side from its shape and consistence was believed to be an ovarian cyst, about the size of a foetal head. During the examination two pieces of decidua, each about a square inch in size, came away. The fœtus was made out to be about seven pounds in weight. The patient would not submit to any operation. The next day feverish symptoms set in, and on the fourth day she suddenly collapsed and died. A living child, weighing eight and a quarter pounds, was removed by abdominal section five minutes after death, but it only lived ten minutes. Six to eight pints of fluid escaped at the moment of opening the abdomen, but no portion of foetal membranes could be found.

Dr. Kundrat on the next day made a necropsy. The organs of the head and chest were normal. There were five or six pints of turbid serous fluid in the peritoneal cavity. The omentum was adherent, and the anterior walls and the peritoneum were injected, and covered with a deposit of loose false membrane. On removal of the small intestines the cavity in which the foetus had lain was apparent. The anterior and lateral walls were formed of a thick false membrane, two or three lines thick, covering the abdominal parietes. The posterior and superior walls were formed slightly by the posterior abdominal parietes, but chiefly by the small intestines, which were connected by membranous bands, and by the ascending and descending colon. The inferior wall was made up partly of a tumour, and partly of the various pelvic organs bound together. There were numerous fibrinous bands stretching across from one side of this cavity to the other. The uterus lay to the left; it was five inches long, and close to the orifice of the left Fallopian tube was the spot through which the sound had penetrated. The left ovary was of normal size; the right was reduced one-half, and, with the right Fallopian tube, was bound down to a swelling six inches long, five wide, and four thick, lying partly on the right iliac fossa and partly on the pelvis, and united to the posterior abdominal wall by thick false membranes. This tumour contained the placenta. The walls of the tumour consisted of firm strong layers, three or four lines thick. Opposite the uterus there was a small round opening, with a sharp margin about an inch across, through which the cord passed from the placenta to the foetus. It was wound round the uterus and slightly attached to it. From the opening, brownish-yellow wrinkled foetal membranes, evidently belonging to an earlier stage of pregnancy, bulged out around the umbilical cord. The walls of the tumour in which the placenta was were quite smooth to the touch.

From this condition of things there can be no doubt that the ovum burst at an early period of pregnancy into the peritoneal cavity. The extraordinary part is, that with the exception of continuous pain and gradual emaciation the woman never had a day's illness. The rupture took place most probably about the third month. The tumour was nourished by branches from the iliac arteries. The distal end of the right Fallopian tube was intimately connected with the tumour. Whether it was a tubar or tubo-abdominal pregnancy could not be distinctly made out.—*London Medical Record*, Oct. 21, 1874.

Two Cases of Extrauterine Pregnancy followed by Recovery.

M. GERPOUILLOT DE MENTHIN reports, in the *Archives de Tocologie* for 1874, a case of extrauterine pregnancy, terminating at the end of fourteen years by the expulsion of the entire skeleton of the foetus by the rectum. The case was that of a woman who, after having presented all the signs of pregnancy, was not delivered at the presumable termination of gestation. The abdomen diminished in size so much as only to present a small development, which was attributed to the presence of an intra-abdominal fibrous tumour. Fourteen years afterwards, after having felt somewhat acute pains in the abdomen, this woman expelled by the rectum all the parts of the skeleton of a foetus in succession. In two days she was in her usual state of health. A second case is reported by Dr. Woodbury, and refers to a woman, thirty years old, who, after twelve years of marriage, complained of a very painful tumour situated in the left lumbar region. The neck was large and open. Ergot of rye was given, so as to bring on the expulsion of a product of conception which was supposed to be inclosed in the uterus. A month subsequently, a discharge of blood from the rectum occurred, followed by the expulsion of a child's arm. The next day the patient felt something in the rectum which she could not expel. It was extracted, and found to be the greater part of a foetus, the placenta, and the umbilical cord which had remained attached to it. The patient completely regained her health.—*British Medical Journal*, Oct. 24, 1874.

On Multiple Disjunctions of the Bones of the Face in a Fœtus.

M. CH. H. PETIT (*Le Progrès Médical*, p. 413) relates a case of a presentation with prolapse of an arm and the cord, thrombus of the vulva, and rupture of the uterus.

The medical man who attended the patient stated that the thrombus appeared before making any attempts at delivery. He applied the forceps, but entirely failed after repeated trials to effect delivery. When admitted into the hospital under M. Chantreuil, she was in a collapsed state; that gentleman replaced the arm, and recommended no further intervention but to stand by and watch until the head came down, which he thought would slowly take place; but should the head not rotate, then he would perform cephalotripsy. The arm again came down, the patient became more and more restless until the pains gradually died away, and she sank ten hours after her admission. M. Chantreuil declined to interfere, as it was useless. The necropsy showed a rupture of the uterus at the right side with the fœtus half projecting through it into the abdomen. The fœtus was beginning to decompose. The remarkable part was that the bones of the face and portions of the several bones were completely disarticulated. The lower jaw-bone was separated at the symphysis. The malar bones were disjoined from the zygomatic processes and from the superior maxillary bones; the latter were separated from each other, and the sutures between the nasal processes and the frontal bone were disjoined. The same was the case with the connections between the vomer and the palate and other bones. Where these separations had taken place the periosteum was torn off; but there was no infiltration or escape of blood in the vicinity of these joints, showing they were *post mortem*, and evidently caused by the force used in the attempts at extraction by the forceps. M. Chantreuil believes that, if the woman had been left to herself, and there had been no attempt at delivery, either by version or forceps, she would have done well. Interference had excited strong uterine contractions, which terminated in rupture of the uterus.—*London Medical Record*, Oct. 21, 1874.

On Uterine Souffle after Confinement.

In instituting researches into this physiological phenomenon, M. BAILLY (*Archives de Tocologie*, 1874) has been actuated by a desire to see what effect the process of involution had on its frequency, its tone, its intensity, its duration, etc.; its practical application may not as yet be apparent, and its importance he in no way wishes to exaggerate.

Frequency.—He made observations upon seventy-eight women, taken promiscuously amongst the patients. A bruit was discoverable sixty-eight times, or in the proportion of 87.1 per cent. Amongst *enceinte* women, M. Depaul found that it existed in about 95 per cent. of the cases examined. It is, therefore, rather less frequent than Depaul thought.

Character.—In the large majority of instances the tone was soft, liquid, and prolonged, not unlike the sound of the syllable *vous*, when spoken slowly by a bass voice; it is always intermittent, and its duration is longer than the pause. The *bruit de diable*, so frequently heard during pregnancy, was not once observed. The *intensity* is about the same as the souffle heard between the fourth and fifth month of pregnancy. Three or four times it was as loud on the morrow of the confinement as at the end of pregnancy. The larger the uterus, the louder the sound.

The chief difference in the souffle in the *enceinte* woman and the puerperal woman consists in the tone of the latter being of less volume, less lasting, and less strong. The sibilant, musical, and rough notes, often heard in the pregnant woman, are very rare in the other.

The sound is generally heard over the sides or over the lower half of the uterus, rarely over the superior moiety. It predominates on the left side; out of fifty-eight cases it was found of equal intensity on both sides fifteen times, stronger on the right thirteen, and on the left twenty-six times. The position of the uterus did not alter the ratio.

Progress and Termination.—There is an intimate connection between the subsidence of the uterus and the disappearance of the bruit. In the majority of cases it disappears when the uterus is about 11 or 12 centimètres above the symphysis pubis, but in some cases it has been observed to vanish when the womb was 14 or 15 centimètres above the pubes, and to exist when it was 8 to 10 centimètres, and that two or three days after labour.

Duration.—The maximum was in forty-seven women 138 hours; the minimum ten hours, the mean sixty-three hours. Circumstances influencing the force and duration of the souffle are, the contractions of the uterus, death of the foetus *in utero*, long previously, and profuse hemorrhage. In two cases of puerperal fever, the sound was heard for two days in spite of the fever. The uterine contraction either enfeebles the sound, rendering it very short and very harsh, or completely arrests it; only once was it found to increase it. The delivery of a macerated child increases the tone; the same is observed *ante partum*. The explanation is, that the death of the foetus lessens the vitality, and as a consequence the tonicity, of the uterus, and increases the disparity of size between the extrauterine arteries and their interstitial branches. Excessive hemorrhage is believed to act in the same way.

Anatomical Seat and Approximate Cause.—The observations made during the investigation of the *post-partum* uterine souffle fully coincide with those of MM. Chauveau and Boudet, and conclusively prove that it has its seat in the arterial uterine system, and that its approximate cause is the passage of the blood from relatively smaller vessels into larger sinuses and vessels. M. Bailly comes to the following conclusions:—

1. The expulsion of the child and the secundines does not at once arrest the uterine souffle of pregnancy, but nine out of ten times it exists a variable time after delivery.

2. Its tone is soft, without pulsation, and clearly intermittent. Any other character is very exceptional.

3. The intensity of the souffle gradually diminishes until it entirely disappears. As long as it lasts, it alternates between more or less elongated increase and diminution, of which the exact cause is not very apparent.

4. Its mean duration is between two and three days (sixty-three hours); in rare instances, it is prolonged to the sixth day.

5. The souffle cannot have its seat in the vessels situated behind or at the sides of the pelvis, but evidently depends on modifications impressed on the vascular apparatus of the womb by pregnancy, which is conclusively proved by uterine contraction, either enfeebling or completely suppressing it.—*London Med. Record*, Oct. 21, 1874.

On Occasional Arresting and Disquieting Influence of Pregnancy over Pelvic Abdominal Tumours.

Dr. ALEXANDER MILNE read a paper on the subject before the Obstetrical Society of Edinburgh, on May 13, 1874, illustrating it by three cases (*Edinburgh Medical Journal*, August, 1874). He combats the view that has been held by most authorities, that pregnancy is favourable to the growth of cysts, exciting inflammation, or causing adhesions, or leading to suppuration, and that women with cystic ovaries should either not marry, or, if married, should refrain from intercourse.

He relates three cases, showing that it had the most beneficial effect in causing complete absorption of the ovarian cyst.

Case 1.—A single lady consulted him previously to marriage, in whom he discovered in the right utero-rectal fossa a unilocular ovarian cyst, about the size of an orange. About the end of the fourth month of pregnancy, she was seized with sharp pains over the abdomen, and was exceedingly prostrate when seen, rejecting all food. Pain was relieved by opium, and the vomiting ceased in a couple of days. She was delivered at full time with a healthy child; and has had two children since. The tumour quite disappeared. [It is not stated when the cyst disappeared, whether before or after her first confinement, or one of the subsequent labours.—*Rep.*]

Case 2.—A married woman, mother of three children. When in labour with her fourth child, there was found to be a large elastic tumour in Douglas's pouch: it was pushed above the brim, and the delivery was rapidly and safely accomplished. A couple of years afterwards she was again brought to bed; this time the tumour came down as before, but was much smaller. This year she gave birth to a child; the cyst was to be felt, but so much diminished in size that it required no interference.

Case 3.—This case was somewhat similar to the last. The patient was a multipara. The tumour could not be returned, and had to be delivered by turning twelve hours after parturition. There were intense abdominal pain and other symptoms of peritonitis. The woman recovered. Dr. Milne had not seen her since to make any examination as to whether the tumour had diminished or not, but he believed such to have been the case.

These tumours were all diagnosed as unilocular ovarian cysts, and were discussed, the writer believes, through the pressure of the gravid uterus, acting similarly to the effect produced by external bandaging. Instead of matrimony or intercourse being prohibited, it should be regarded as a remedial measure. —*London Med. Record*, Sept. 9, 1874.

—

On Esthiomène, or Lupus of the Genitals.

Dr. BERNUTZ, in the *Archives de Tocologie* for July, 1874, states that he has only seen five cases of this disease during twenty-five years' hospital practice. It differs in no respect from the lupus that affects the body generally, but in the anatomical difference of the structure affected. There are two forms—the erythematous and the tubercular. The former is the more rare, and is characterized by a reddish-violet blush, similar to what is observed in the face. It is always connected with the other variety. It consists of a softening of the cutaneous tubercles, which helps to diagnose it. The latter form is the more common, and is to be observed uniquely on the "*Privates*." It is seen most characteristically on the mons Veneris, on the external surface of the labia majora, and on the perinæum. Its differential diagnosis, especially the ulcerative form, from two varieties of syphilitic ulcerations, is very difficult. It is the more so, as many affected with this disease have very suspicious antecedents. The chief signs are its dull-red tinge, covered with a layer of imperfect epithelium, and, finally, its progress; healing on one side, breaking out on the other, in parts oscillating between an ulcerated surface and cicatrices. Neither in syphilides nor in canceroids is this peculiar feature observable, which in a marked manner distinguishes it from all other affections. He relates a case, occurring lately in a married woman, of a scrofulous history, but with no trace of syphilis. It seemed to result from poor living and bad air. She had given birth to a child a few months before; since that time she had had leucorrhœal discharge. Careful microscopical examinations of portions of the parts affected were made by M. Martin. The papillary vegetations were covered with thick layers of epithelium, more deeply of connective tissue, with an alteration in the lymphatics. There were a few fibrillæ of areolar tissue containing small round embryonic cells. The inner lining of the bloodvessels was formed of swollen epithelial cells containing ovoid and large nuclei. The cellular tissue which formed their base consisted of thin fibrillæ, and of elastic tissue in the form of a network. The most marked peculiarity existed in the lymphatics, which were thick, sometimes spherical, sometimes ovoid or cleft on section. The internal surface had one or two layers of epithelium. The cells of the most external of these two layers contained large ovoid nuclei stained red with carmine. In the innermost layer the cells were irregular, incomplete, having nuclei, large, spherical, at times stained by carmine through their whole substance, at others only at their margins. The central canal contained a coagulated material, uniformly coloured of a deep red with carmine. The changes were exactly analogous to those described by M. T. Renaut in the *Archives de Physiologie*, July, 1872. The treatment consists in improving the general health, excising

certain portions, and applying pledgets of lint dipped in tincture of iodine, and an opiate cerate, so as to exert pressure on the parts.—*London Med. Record*, Oct. 14, 1874.

—
On Constriction of the Vagina, Vaginismus Superior, and Vaginismus properly so called.

In the *Gazette des Hôpitaux* (August 29, 1874) Dr. VICTOR REVILLOUT investigates a case that very much surprised him, and which appeared inexplicable from our present state of science.

Three years ago a young woman, a primipara, came into the Hotel-Dieu to be confined. The labour was prolonged. The *interne* applied the forceps. The blades were apparently introduced with ease, the head of the fœtus being at the brim. As the first efforts at traction was ineffectual, the forceps was removed, and the physician in charge was sent for. He arrived in three-quarters of an hour. On attempting to apply the forceps, he found it impossible to do so, as, a little below the os, the vagina was divided into two parts by what seemed to be a kind of double band, stretching completely across from before backwards, almost perpendicularly to the axis of the body. In spite of the affirmation of the *interne*, he refused to admit that the blades had ever been passed, and the bands were, in his estimation, cicatricial. He made a long incision on each side of the vagina parallel with its axis, almost perpendicular to the base of these two folds. The fœtus was then extracted without difficulty.

The woman died three days afterwards of uterine phlebitis. In making a *post-mortem* examination, not a trace of any cicatricial band could be found. The vagina was healthy and normal. Around the wounds there was no projection whatever to explain the necessity of making the deep incisions. Nevertheless, it could not be supposed that the practitioner was mistaken, in believing that he felt a very tense double fold projecting into the vagina. The assistant had also examined the vagina before the incision was made, and felt equally convinced, to his astonishment, that such was the case. It was now, however, evident that the phenomenon was a temporary one, and that for its explanation it was necessary to have recourse to the hypothesis of muscular contraction. But where was the portion of muscle that was contracted? It was scarcely possible to conceive that it was a part of the muscular fibres of the vagina, as in that case the constriction would have been circular, and not from before backwards. Outside the vagina, there is no muscle as yet described that could produce constriction.

Shortly afterwards, another case came under observation, somewhat similar in its character, and which helped to explain somewhat the remarkable features of the previous one. A woman, a multipara, with old ruptured perinæum, complained that at times the act of intercourse was not only painful but impossible, from some constriction a short distance up the passage, although the vagina was, in general, sufficiently capacious. An examination showed at first nothing abnormal; she was desired to squeeze the exploring finger, if possible, and was able to do so with considerable force, relaxing or contracting the vaginal wall at will. On pushing the inquiry still further, it was found that there was a sensitive part a short distance inside the orifice of the vagina, and at the cervix. The slightest touch of these parts produced an effect similar to that called into action by the will.

Gosselin, under the name of Vaginismus superior, in his *Leçons cliniques*, published last year, speaks of a hyperæsthesia of the vaginal *culs-de-sac* without contraction of any kind. In acute vaginitis, from the painful spasmodic contractions of the vagina, a small body is, in some cases, incapable of being passed. As this condition has been denied by some authorities, amongst whom is Guéneau de Mussy, the writer made some careful dissections to see what were the anatomical relations of the muscles surrounding the vagina.

The vagina crosses the superior perineal aponeurosis very obliquely, from below upwards and from before backwards. On measurement of the length of the vaginal walls below this plane, the posterior is about double the length of the anterior. The disposition of the muscular fasciculi is very peculiar in the

perineal region. The vagina is divided by the superior perineal fascia into two parts, an inferior and a superior. The inferior or perineal portion is rich in muscular fasciculi; the upper part contains but few striated or voluntary fibres. On the lower half of the vagina the muscular fibres, for the extent of about seven centimetres, pass both from before and backwards obliquely towards the rectum, but more especially in the antero-posterior direction. At the point of junction of the posterior surface of the vagina with the anterior wall of the rectum, there is a small triangular space, with its base posteriorly. It is free of any muscular fasciculi, both behind and at the lateral surface of the vagina. The first fasciculi, which are inserted in the anterior surface of the obturator fascia, and in the centre of the aponeurosis, are more considerable than are generally described in anatomical works. They form, as it were, a trapezoid, nearly triangular, the fibres being spread out fan-shaped over the sides of the rectum, and encompassing the vagina to about the height of four or four and a half centimetres on its posterior margin. The inferior fasciculi do not deserve the name of elevators of the anus, for they really serve to constrict the vaginal orifice, as they are directed obliquely from above downwards, or from before backwards; but it is not so with the superior, which are oblique and represent a constrictor muscle, as described by Cruveilhier. There is another bundle of muscular fibres arising slightly more externally and more posteriorly, of triangular formation. They arise from the inferior surface of the superior aponeurosis, a little below the line of junction of the fascia with the vagina. They strengthen the vaginal and rectal walls as they pass downwards, spreading out in the form of an elongated fan, whose base is about two centimetres. These fasciculi are exceedingly strong, and are composed of well-marked striated fibres, which was verified by M. Damaschino under the microscope. A portion of these fibres lose themselves on the surface of the rectum: others seem to be inserted more distantly.

This curious disposition of the fibres has been never previously described. A contraction of these powerful fasciculi would narrow laterally the middle portion of the vagina, which was the case in the two above-mentioned patients. Their presence explains vaginismus, and their tonic contraction, the narrowing of the vagina in virgins, and in some women up to parturition; they also form the corrugated surface of the vagina.—*London Med. Record*, Oct. 14, 1874.

— On Bloodless Extirpation of Tumours of the Vulva.

M. VERNEUIL (*Gazette Hebdomadaire de Médecine et de Chirurgie*, June 5, 1874) relates the following six cases:—

Case 1. An epithelioma of the left labium majus and corresponding vaginal wall was treated by the *écraseur*, the chain being applied first by aid of a curved trocar and caula plunged under the growth. The chain had to be applied in four different directions, and the operation, though successful and bloodless, occupied forty-five minutes. Cicatrization was complete in a few weeks. Eighteen months afterwards there was no sign of return; and an enlarged inguinal gland had disappeared.

Case 2. An epithelioma, occupying nearly the whole length of the left labium, was removed in a few minutes by a double-chained *écraseur*, invented by M. Verneuil.

Case 3 was one of very large epithelioma of the superior commissure of the vulva, implicating the *mons Veneris*, both labia, and the region of the clitoris. A groove was first marked out round the tumour with the galvanic-cautery knife, and then the operation was completed by two *écraseurs*, worked simultaneously. The operation was successful, but a return of the disease carried off the patient in seven months. So completely was M. Verneuil satisfied with the galvanic knife here, that in the three other cases he employed it alone.

Case 4 was one of epithelioma of the left labium majus. The growth was drawn forward by the left hand, while a groove was traced round it with the galvanic-cautery knife, and then the base was separated. The knife (wire) was kept at a dull-red heat, and the operation only occupied four or five minutes—

a period sufficiently long to complete it without loss of blood or use of ligatures. The patient did well at first, but eventually died from extensive gangrenous erysipelas.

Case 5. In this case, one of enormous elephantiasis of the labia and mons Veneris, in a girl, aged twenty, a groove was again traced round the growth with the galvano-cautery; but as it had been used for the previous case, the fluid in the battery became exhausted, and M. Verneuil tried to complete the operation with the *écraseur*. He found, however, the skin so hard and the progress so slow, that he was afraid of breaking both chain and rack, and had the battery refilled, and finished with the galvano-cautery. To fix the chain of the *écraseur*, it was necessary to cut a little with scissors, and the free hemorrhage showed what might have been expected if the whole had been a cutting operation. The time occupied was forty-five minutes. He makes the following remarks on this case: 1. It is quite possible to follow easily with the eye what the galvano-cautery knife is cutting. Here he was even able to work more slowly when dividing small vessels. He even thinks it easier than when the parts have acquired a general red hue from sponging during a cutting operation. 2. Vessels divided by the cautery can still be ligatured, and if over a certain size require to be. 3. He alludes to the hemorrhage when the scissors were used a little; also 4. To the hardness of the growth, and the danger of breaking the *écraseur*. 5. The bath of the battery can be refilled in a few minutes, if the whole be first plunged into a pail of cold water to cool it. The edges of the wound were partly drawn together by silver sutures, and a dressing of wool dipped in alcohol and carbolic acid used. The operation was done on April 1 (the same day as Case 4), and the patient was quite well on May 18, never having had a bad symptom.

Case 6 was one of erectile venous tumour on the labium of a girl aged six. As it was difficult to surround the growth with the cutting loop of the cautery, M. Verneuil used the knife (cautery) and made a regular dissection, the so-called knife being a fine wire of platinum, heated to a dull-red. Two or three minutes completed the operation. A simple water-dressing was used, and the patient had a narrow escape from a very severe attack of erysipelas, with abscesses, etc., but ultimately recovered, merely a small linear cicatrix remaining, and the labium being natural in shape.

In some concluding remarks, M. Verneuil points out that there is no greater immunity from erysipelas, pyæmia, and like diseases, after these bloodless operations than when the knife is used. An epidemic of erysipelas was raging at the time when the last three cases were operated on; but he cannot admit contagion in the case of the little girl, who was a private patient, and whose wound he did not touch, the mother dressing it.

[M. Verneuil acknowledges that the discharge in the last case was putrid, and it is to be noted that of the three the one dressed with an antiseptic dressing escaped the disease. With regard to the other cases, they are very interesting and instructive, and amply support M. Verneuil's advocacy of the galvano-cautery. Few will be disposed to differ from him who have tried it in like cases.

In the cases the reporter has seen, however, he cannot say it was quite so easy to follow the wire and see what it was cutting as M. Verneuil has found it.—*Rep.*—*London Med. Record*, Sept. 23, 1874.

Medical Jurisprudence and Toxicology.

On a New Method of treating Dangerous Symptoms presented during the Administration of Chloroform.

Dr. JACOB HEIBERG, of Christiania (*Berliner Klinische Wochenschrift*, No. 36, 1874), describes certain manipulations for the relief and removal of disquieting symptoms often presented during the administration of chloroform.

These consist especially in noisy and retarded respiration, congestion or pallor of the face, and a small pulse. This condition, frequently met with in hospital practice, is usually treated by forcible separation of the jaws, and by dragging the tongue forwards with large forceps or sharp hooks. To these proceedings the author raises the objections that they interfere with the course of the operation, and distract the attention of the surgeon; that the tongue is often wounded by broken or sharp teeth; and, thirdly, that the quantity of chloroform used is often necessarily increased, and the subsequent ill effects of the narcosis rendered more intense. The manipulative proceeding, recommended by the author, consists in depressing the lower jaw *in toto*. When the respiration becomes noisy and disturbed, and in all cases where hitherto the teeth have been separated and the tongue pulled forwards, Dr. Heiberg would depress the jaw in the following manner. The chloroformist, standing behind the recumbent patient, places both thumbs on the symphysis of the lower jaw, passes the second segment of the flexed index finger behind the posterior margin of the ascending ramus of the lower jaw on each side so as thus to hold fast the whole bone between both hands, and then with some force drags the jaw directly forwards. The whole jaw may thus be made to glide forwards, so that the lower dental arch stands in front of the upper arch. This proceeding, which may be carried out with special facility in children, is at once followed by deep and perfect respiration. So long as the jaw remains dislocated, so to speak, respiration is unimpeded and quiet, and just the same result is obtained as from traction on the tongue. Dr. Heiberg states that the anatomical reason for this favourable result is not quite clear to him, but he thinks it probable that the epiglottis lying over the rima glottidis may be thus elevated. The following are supposed to be the chief advantages of Dr. Heiberg's proceeding: 1. The operator can do his own work with less disturbance, and the operation can be performed quietly, and with more safety. 2. Lesions of the teeth and tongue are thus avoided. 3. Less chloroform is used, the after-effects of the narcosis and the dangers of chloroformization being thus lessened.—*London Medical Record*, Oct. 21, 1874.

On Acute Ergot-Poisoning.

Dr. HENSCHEL reports a case in the *New York Medical Record* for September 1, 1874, where thirty minims of Squibb's fluid extract of ergot were given by mistake to an infant. Soon afterwards, there were severe abdominal pains, recurring every fifteen minutes and lasting hardly sixty seconds. There were slight tetanic contractions of muscles of face and extremities. Diarrhœa set in four hours after administration, and continued fourteen days. He believes that this case proves that it is the uterine contractions, and not the ergot, that destroys the fœtus during labour.—*London Med. Record*, Sept. 30, 1874.

Lead as a Constituent of Enamel the Cause of Chronic Poisoning.

The patient at first was suspected to have typhlitis, but after four weeks had elapsed a slate-coloured band made its appearance on the gums, and bladder-tenesmus became apparent. Upon this appearance a diagnosis of lead poisoning was arrived at. Soon after this the sister of the patient was similarly attacked.

The source of the lead poisoning was shortly afterwards detected. The jar used as a receptacle for vinegar was found to be much corroded, and nearly all the enamel was removed by the vinegar. The vinegar possessed a disagreeable sweetish taste. One "schoppen" was placed in the jar for ten hours, when, on examination, 0.09 grm. of metallic lead was found. The jar, when full of vinegar, must have contained, after standing ten hours, 1.8 grm., and after standing one week must have contained 30.24 grms. of lead in solution. About one jar of vinegar was consumed per day, which was quite sufficient to produce lead poisoning in the family.—*Medical Record*, Oct. 15, 1874.

The Poisonous Nature of Red Wall Papers.

The dangers to be feared from wall-papers, stuffs, laces, and flowers, dyed green by the agency of arsenite of copper, have long been patent to the world. The particles of arsenic which become detached from articles so coloured have given rise to undoubted cases of poisoning, as well as to much unaccountable ill health. This danger is particularly great in ball-rooms, where the particles detached from the dresses and flowers worn by the ladies is in constant agitation in a condensed and heated atmosphere. To these dangers appertaining to articles dyed green must now be added, according to an article in the *Gazette des Hôpitaux*, a fresh series, which have been traced to wall-papers and materials dyed red with coralline dye. It was believed for some time, some years since, that this material, which was used to dye stockings, socks, and other woollen goods, a magnificent red, was poisonous. A young man who wore red socks, having been attacked by a very acute and painful vesicular eruption on both feet, M. Tardieu attributed this affection to the red colour of the coralline dye. The substance in question having been separated by M. Roussin, the chemist, and injected under the skin of a dog, a rabbit, and a frog, which died from its effects, it was concluded to be a violent poison, and subsequently fell out of use as a dyeing agent. Contradictions of this statement, however, were soon forthcoming; M. Landrin, a veterinary surgeon, asserted that he had administered coralline to dogs and cats without observing any subsequent ill effect. He had had positive proof of the absorption of the coralline and of its purity, since he had been able to collect it in the lungs of the animals, and to dye silk with it. Dr. Guyot confirmed these experiments, and came to the conclusion that coralline was not poisonous, even in large doses, and that it may be safely used in dyeing, *provided that it be not mixed with poisonous substances.*

In presence of these contradictions between men of equal education and veracity, doubt was permissible, and things remained in this state. M. Bouchardat had often had an idea that signs of poisoning by local applications of Scheele's green or arsenite of copper were present in some cases from the nature of the symptoms recorded; but this was an *à priori* explanation which was far from convincing. The question was still environed by mystery, when it was cleared up by a most singular incident. Dr. Bijon, a physician of Quimperlé, had an apartment hung with *fentre Pavy*, a wall-paper with a red pattern on a hazel-brown (*noisette*) ground. Whenever he inhabited this room, he was annoyed by prickings of the eyelids, with itching and burning sensations; he was even attacked by purulent conjunctivitis after having slept for several nights in this room. He had the paper analyzed, and, from a piece of ten square *centimètres* (0.12 square yard), MM. Mayer and Lebaigue obtained, with Marsh's apparatus, enough arsenical patches to cover a saucer. They were also able to extract from a larger quantity of this paper enough coralline to submit it to reagents, to dye silk and wool with it, and to obtain sufficient arsenical patches to enable them to affirm that the red substance employed to colour the paper was undoubtedly coralline, and that, in its use as a dye for paper, it was an arsenical substance, as M. Bouchardat had foreseen; though M. Roussin had not been able to recognize it as such. M. Mayer could not obtain any patches of arsenic by submitting the brown portions of the paper to the action of Marsh's apparatus; and therefore came to the decision that the arsenic was only mixed with the red colour of the paper, that is, with the coralline dye.

An apparent contradiction is thus solved. It results that pure coralline is not poisonous, and may be employed as a dye; but, in materials as well as in wall-papers, an arsenical mordant is often used to fix it. This mordant, then, acts as a poison, whether acting topically on the skin, where it is directly deposited, through the medium of red shirts, drawers, and stockings, or by the dust and vapours which disengage themselves from the papers or stuffs dyed with it.—*British Medical Journal*, Oct. 10, 1874.

CONTENTS.

Anatomy and Physiology.	
The Physiology of the Kidney. By M. Charcot	241
On Recurrent Sensibility. By MM. Arloing and Tripier	242
Materia Medica and Therapeutics.	
On the Therapeutic Properties of Bromide of Camphor. By Dr. Bourneville	243
On the Action of Strychnia. By F. A. Falek	244
Note on the Nitrite of Amyl. By Dr. J. Crichton Browne	246
On the Antiseptic Properties of Salicylic Acid. By Professors Kolbe and Thiersch	246
Medicine.	
On the Hypodermic Use of Atropia in Muscular Rigidity, Rheumatic, and Myalgic. By Dr. J. C. Wilson	248
On Auditory Vertigo (Ménière's Disease). By Prof. Charcot	248
On Certain hitherto Unrecognized Movements of the Extremities in Hemiplegics. By M. Bernhardt and Dr. Westphal	251
Reflex movements of the Sound Hand caused by Slight Irritation of the Skin of the Paralyzed Hand. By Dr. Putnam	253
On the Curative Treatment of Insanity by Chlorohydrate of Morphia. By Dr. Voisin	253
On Syphilitic Meningitis and Syphilitic Cerebral Disease. By Dr. Bruberger	254
On Ipecacuanha Spray in Winter Cough and Bronchitic Asthma. By Dr. Sydney Kinger and Mr. William Marrell	255
On the Use of Carbolic Acid in Cheesy Pneumonia. By Prof. Tommasi	256
On the Symptoms of Tubercularization in Children, and their Semelological Value. By Dr. J. Grangé	257
On Acute Phlegmonous Periostitis with Ulcerative Endocarditis. By M. Hirtz	257
On Hepatic Syphilis in the Adult. By M. Lacombe	258
Pseudo-Membranous Enteritis. By M. Wannebroncq	258
Surgery.	
On the Treatment of Wounds. By Dr. G. M. Humphry	259
On Herpes Corneæ. By Dr. Pflüger	260
On Serous Cysts of the Iris. By Drs. Hesch and Sattler	260
On Pulsation of the Retinal Arteries in Aortic Disease. By Dr. Grandclement	260
On a New method of Operation for Entropion and Trichiasis of the Upper Eyelid. By Dr. Warlomont	261
Removal of Plaster of Paris from the External Auditory Canal. By Mr. Dalby	262
On Salivary Fistula. By Dr. Prompt	263
On Gastrotomy for Internal Strangulation. By Prof. Berti	263
Case of Perityphlitis; Operation on the Eighth Day; Recovery. By Dr. Charles Kelsey	263
On Hypospadias. By Dr. S. Duplay	264
On Obstruction of the Left Ejaculatory Duct by Concretions from the Vesicula Seminalis (Spermatic Colic). By M. Réliquet	265
On Urethro-rectal Fistula following an Abscess of the Prostate. By M. Schwarz	266
On Tuberculous Ulceration of the Anus and of the left Buttock in a patient suffering from Pulmonary Phthisis and Tuberculous Ulceration of the Fauces. By M. Martineau	267
On Subcutaneous Fracture of Exostosis of the Femur. By Dr. Chiene and Mr. Mander	268
On Three Remarkable Cases of Dislocation. By M. D. Mollière	269
Dislocation of the Head of the Femur into the Great Ischiatic Notch; Fracture of Neck following attempted Reduction at the end of nine weeks. By Dr. Dawson	270
A Rare Form of a Congenital Cystic Fibroma Molluscum of the Elbow; Removal by Operation; Successful Result. By Dr. Charles B. Brigham	271
On the Treatment of Hygromata containing False Cartilages. By Prof. Volkmann	272
Case of Spina Bifida (Dorsal) cured by Injection. By Dr. James Morton	272
Traumatic Facial Neuralgia; Excision of a Portion of the Inferior Dental Nerve and of the Infra-orbital Nerve; Complete Relief. By Dr. Charles B. Brigham	273
Neuralgia of the Lower Jaw and Tongue treated by Excision of the Nerve. By Dr. Theo. A. McGraw	275
Midwifery and Gynæcology.	
On a Case of Twins at the Eighth Month, with a Peculiar Ring-shaped Low Situation of the Placenta, without Hemorrhage. By Prof. Alois Valenta	275
On Bifid Vagina as a Cause of Impediment to Delivery. By Dr. Valenta	276
On Prolapse of the Umbilical Cord. By Dr. Geo. Engelmann	276
On Bleeding to Death of the Fœtus during Parturition. By Dr. Valenta	277
On a Case of Extrauterine Pregnancy. By Dr. Ludwig Bandl	277
Two Cases of Extrauterine Pregnancy followed by Recovery. By M. Gerpouillot de Menthin	279
On Multiple Disjunctions of the Bones of the Face in a Fœtus. By M. Ch. H. Petit	280
On Uterine Souffle after Confinement. By M. Bailly	280
On Occasional Arresting and Disquieting Influence of Pregnancy over Pelvic Abdominal Tumours. By Dr. Alexander Milne	281
On Ecthiomene, or Lupus of the Genitals. By Dr. Bernutz	282
On Constriction of the Vagina, Vaginismus Superior, and Vaginismus properly so called. By Dr. Victor Revillout	283
On Bloodless Extirpation of Tumours of the Vulva. By M. Verneuil	284
Medical Jurisprudence and Toxicology.	
On a New Method of treating Dangerous Symptoms presented during the Administration of Chloroform. By Dr. Jacob Heiberg	285
On Acute Ergot-Poisoning. By Dr. Henschel	286
Lead as a Constituent of Enamel the Cause of Chronic Poisoning	286
The Poisonous Nature of Red Wall Papers	287

Published Monthly in conjunction with the MEDICAL NEWS AND LIBRARY at \$3.50 per annum in advance, free of postage.

Also, furnished together with the AMERICAN JOURNAL OF THE MEDICAL SCIENCES and the MEDICAL NEWS AND LIBRARY for SIX DOLLARS per annum in advance, the whole free of postage.

HENRY C. LEA, Philadelphia.

INDEX.

- Abortion, opium and chloral in, 42
 Acne due to bromide of potassium, 165
 Addison's disease, urine in, 202
 Ailanthus glandulosa in dysentery, 160
 Albuminuria as a symptom of the epileptic paroxysm, 108
 Alcohol, action of, 11, 148
 Alopecia, 163
 Amblyopia, bromide of potassium in, 212
 Amory, rupture of heart, 22
 Amussat, electricity for cysts of neck, 80
 Amyl, nitrite of, 246
 Anæmia, effect of, on nutrition of heart, 114
 Anæsthesia, obstetrical, 186
 Anæsthetization during sleep, 46
 Aneurism, arterio-venous of arch of aorta, connecting with left brachio-cephalic vein, 159
 ———, embolism as a cause of, 14, 65
 ——— of aorta treated by gallic acid and subsulphate of iron, 115
 ——— of dorsalis pedis, traumatic, 223
 ——— of radial artery, 84
 ———, popliteal, treated by ice, 35
 Anstie, bromide of potassium, 5
 ———, poisoning by chloral, 191
 Anus, tuberculous ulceration of, 267
 Aponiophia, physiological action of, 102
 Apoplexy, relation of renal, with cerebral hemorrhage, 117
 Arloing, recurrent sensibility, 242
 Arm, amputation of, with scapula, etc., 131
 ——— and scapula wrenched off, 35
 Arnold, osteoma of frontal sinus, 216
 Arsenious acid, physiological action of, 198
 Asthma, ipecacuanha spray in, 255
 Ataxic, spontaneous fractures and dislocations in the, 178
 Atthill, ergot in fibroids of uterus, 189
 Auditory canal, removal of plaster from, 262
 Azéma, anomaly of anterior tibial artery, 223
 ———, aneurism of dorsalis pedis, 223
 Bag of waters, premature rupture of, 228
 Bailly, uterine souffle after confinement, 280
 Bandl, extra-uterine pregnancy, 277
 Bardin, treatment of paraphimosis, 82
 Baréty, pulmonary hemorrhage due to cerebral injury, 22
 Barlow, granular kidney in a child, 161
 Bartels, peripleuritis, 209
 Bellamy, fracture from muscular action, 133
 Bellini, iodide and bromide of mercury, 7
 Bergeron, spontaneous fractures and dislocations in the ataxic, 178
 Bernhard, movements of extremities in hemiplegics, 251
 Bernutz, lupus of the genitals, 282
 Berti, gastrotomy for internal strangulation, 263
 Bile in absorption of fats, 52
 Bille, luxation of sacro-iliac synchondrosis, 234
 Binz, bromide of potassium, 5
 Blachez, puerperal tetanus, 233
 Bladder and rectum, perforation of, 222
 ———, cysts on posterior wall of, 172
 ———, passage of hairs from, 222
 Blake, action of salts of soda, 55
 Blane, phosphate of lime and juice of meat in phthisis, 113
 Blood cyst of hand, 174
 ——— in relapsing fever, 199
 ———, tests for, 95
 Bock, sugar in cedematous fluid, 202
 Boechat, structure of thyroid body, 2
 Boehm, action of arsenious acid, 198
 ——— hydrocyanic acid, 103
 Bone, effect of food on composition of, 11
 Böttern, poisoning by colchicin in beer, 142
 Bouchard, valerian in diabetes insipidus, 24
 Bouchut, diphtheria, 60
 Boudon, ipecac in bowel affections, 211
 Bourdon, chloral in puerp. convulsions, 41
 Bourguet, pseudarthrosis cured by irritant injections, 35
 Bourneville, bromide of camphor, 103, 243
 Brain and muscle in relation to epilepsy, 154
 ———, gunshot wound of, 27
 Brandt, treatment of ulcers of os uteri, 93
 Braus, pyometra and pyokolopos lateralis, 141
 Breast, scirrhus of male, 81
 Breasts, triple, 51
 Brigham, nerve excision for neuralgia, 273
 ———, rare form of congenital cystic fibroma molluscum of elbow, 271
 Brochin, trephining of mastoid process, 170
 Browne, nitrite of amyl, 246
 Bruberger, syphilitic cerebral disease, 254
 Bryant, torsion in amputation, 25
 Buccal nerve, section of, by mouth, 80
 Bufalini, camphorated phenol, 8
 Bull, perityphlitis, 68
 Bullets, action of modern, 120
 Union, resection as a remedy for, 225
 Burns, amputation by galvanic cautery, 131
 Buzzard, general paralysis cured by iodide of potassium, 205
 Cæsarean section, 36, 37
 ———, imperfectly healed, cause of death, 88
 Calcium bromide, 6
 Callender, neuralgia treated by nerve-stretching, 74
 Camphor, bromide of, 103, 243
 Cancer, chloral in treatment of, 26
 Carbolic acid in cheesy pneumonia, 256
 ———, subcutaneous injection of, 9
 Carnus, electricity in vitreous opacities, 77
 Caro, swallowing of a shawl-pin, 172
 Carter, abscission of eyeball, 29
 Casa, senile galactorrhœa, 43
 Caselli, amputation of tongue, 29
 ———, ligature of deep femoral artery, 129
 Cassells, alcohol in disease of middle ear, 78
 Castellanos, punctured wound of kidney, 218
 Cataract, senile, opening of capsule before corneal incision in operation for, 122
 Cerebral disease, syphilitic, 254

- Chaboud, arterio-venous aneurism of aorta, 159
- Charcot, diagnosis of hystero-epilepsy, 20
 —, Mènière's disease, 203, 248
 —, physiology of the kidney, 241
- Chiari, quinia as an abortifacient and oxytocic, 58
- Chiene, subcutaneous fracture of exostosis of femur, 268
- Chloral, external application of, 9
 —, poisoning by, 47, 191
- Chloroform, influence of, on fœtus, 89
 —, treatment of poisoning by inhalation of, 286
- Cholera, quarantine in relation to, 236
- Clarke, ichthyosis linguæ, 170
 —, pseudo-hypertrophic muscular paralysis, 107
- Clavicle, removal of entire, 34
- Clements, pruritus urethræ and vaginæ, 90
- Cluness, anæsthetization during sleep, 46
- Cobbold, tapeworm, 118
- Coffee, poisoning by, 95
- Colic, therapeutics of gall-stone, 181
- Colgne, mucous membrane of larynx, 49
- Colchicin, poisoning by, in beer, 142
- Collins, accessory lobe of right lung, 146
- Collodion, poisoning by blistering, 143
- Convalescence, puerperal, 38
- Convulsions, bromide of potassium in albuminuric, 71
 —, from brain disease, 153
 —, puerperal, chloral in, 41
- Cornea, herpes of, 260
 —, metallic deposits on, 169
- Corpus callosum, absence of, 49
- Coughing, physiology of, 99
- Courrèges, alopecia, 163
- Crocq, capillary puncture in glandular swelling, 75
 —, parotiditis as a sequence of acute disease, 156
- Croup, 109
 —, cardiac complications in, 61
- Crystalline, rupture of, 29
- Curschmann, poisoning by coffee, 95
- Cystitis, local treatment of, in women, 186
- Cysts of neck, treatment of sero-sanguineous, by electricity, 80
- Czerny, local osteomalacia, 180
- Dalby, removal of plaster of Paris from external auditory canal, 262
- Dale, liver mistaken for ovarian tumour, 94
- D'Aquin, dengue, 105
- Dargan, senile galactorrhœa, 44
- Dawson, Madagascar ordinal bean, 191
- Dawson, fracture of neck of femur following attempted reduction, 270
- Death, apparent, 4
- Dengue, 105
- Dental nerve, resection of inferior, 226
- Depaul, obstetrical anæsthesia, 186
- De Renzi, rheumatic paralysis of larynx, 22
- Desprès, amputation in continuity of first and fifth metatarsal bones, 175
- Devalz, tracheocele, 216
- Diabetes insipidus, valerian in, 24
- Dickson, brain and muscle in relation to epilepsy, 154
 —, tying umbilical cord, 42
- Diphtheria, 60
 —, cardiac complications in, 61
- Dislocation, three remarkable cases of, 269
- Dixon, poisoning by berries of mistletoe, 46
- Dobrowski on smoked glasses, 59
- Dolbeau, congenital absence of vagina, 44
- Doutrelepont, scirrhus of male breast, 81
- Duplay, hypospadias, 264
- Dysmenorrhœa, conditions which cause, 44
- Dyspepsia, treatment of, 66
- Ear, alcohol in disease of middle, 78
- Edis, vascular growths of the urethra, 89
- Eichhorst, hereditary transmission of progressive muscular atrophy, 17
- Ejaculatory duct, obstruction of, 265
- Emmet, treatment of uterine disease, 137
- Emminghaus, epileptic sweat, 155
- Engelmann, prolapse of umbilical cord, 276
- Englisch, cysts on wall of bladder, 172
- Enteritis, pseudo-membranous, 211, 258
- Entropion, new operation for, 261
- Epilepsy, brain and muscle relation to, 154
 —, diagnosis of hystero, from true, 20
 —, saturnine, 18
- Ergot-poisoning, acute, 286
- Erlenmeyer, poisoning by chloral, 47
- Erysipelas, 27
 — of face, connection of inflammation of heart with, 158
- Esthiomène, 282
- Ether, use of, during labour, 37
- Eucalyptus globulus in puerp. affections, 234
- Exostosis, subcutaneous fracture of, 268
- Eyeball, abscission of anterior portion of, 29
- Face, multiple disjunctions of bones of, 280
- Face-presentations, anomalous, 36
- Falek, action of strychnia, 244
- Fats, bile in absorption of, 52
- Fehling, rupture of vagina, 136
- Femoral artery, ligature of deep, 129
- Femur, fracture of neck following reduction of dislocated, 270
- Fergus, sewer traps, 47
- Fergusson, cleft-palate, 30, 126
 —, hare-lip, 124
- Fibroid, expulsion of uterine, 94
- Fibroma molluscum of elbow, rare form of congenital cystic, 271
- Finch, peculiar laryngeal affection, 208
- Finger, fracture of index, from muscular action, 133
- Finlayson, lancing the gums, 64
- Fistula, salivary, 263
 —, urethro-rectal, 266
- Fœtus, bleeding to death of, 277
 —, malformed, 98
- Foot, amputation of, in the continuity of first and fifth metatarsal bones, 175
- Forceps, Madden's improved, 87
- Ford, phosphorus in insanity, 62
- Fournier, tertiary syphilis, 106
- Fox, treatment of pityriasis rubra, 118
- Fracture from muscular action, 133
- Frantzel, inflammation of mediastinum, 110
- Frey, temporary paralysis, 16
- Fumagalli, rupture of crystalline, 29
- Galactorrhœa, senile, 43
- Galezowski, spontaneous myositis, 28

- Gallasch, leucæmia in childhood, 13
 Gall-stone colic, therapeutics of, 161
 Galvanic cautery, amputation by, 131
 Gastrotomy for internal strangulation, 263
 Gehrung, rest in diseases of chest, 23
 Genital tract, female, exudation near, 90
 Geoffroy, perforation of bladder and rectum, 222
 Gierke, respiratory centres, 52
 Gimbert, bromide of potassium in albuminuric convulsions, 71
 Glandular swelling, capillary puncture in, 75
 Glans penis, angioina of, 220
 Glasses, smoked, 59
 Goitre, epidemic, 21
 Goodell, death from use of sponge-tents, 139
 ———, prevention and treatment of puerperal diseases, 183, 229
 ———, puerperal convalescence, 38
 ———, use of ether during labour, 38
 Gordon, sarcoma of pleura, 65
 Gosselin, benzoic acid for ammoniacal urine, 70
 ———, rupture of tendon of triceps cruralis, 133
 Gowers, convulsions from organic brain disease, 153
 Grandclement, pulsation of retinal arteries in aortic disease, 260
 Grangé, tubercularization in children, 257
 Gray, carbolized ligatures, 25
 Greve, on the act of vomiting, 147
 Guéniot, anomaly of œsophagus, 50
 Gums, lancing of, 64
 Guttmann, bromide of calcium, 6
- Haidenhain, anatomy of the kidney, 97
 Hare-lip, 124
 Hasse, transfusion of lamb's blood, 11
 Haward, blood cyst of hand, 174
 Hayden, contraction of both auriculo-ventricular orifices of heart, 158
 Heart, connection of inflammation of, with erysipelas of face, 158
 ———, contraction of both auriculo-ventricular orifices of, 158
 ———, rupture of, 22
 ———, tolerance of, to wounds, 126
 Hecht, placenta prævia with fibroid of uterus, 39
 Heiberg, poisoning by chloroform, 286
 Hemiplegics, movements of extremities in, 251, 253
 Hemorrhage, pulmonary, due to injury of encephalon, 22
 ———, solution of chloride of iron in post-partum, 39
 Henschel, acute ergot-poisoning, 286
 Herkel, metallic deposits on cornea, 168
 Hernia, retro-peritoneal, 218
 Hicks, treatment of cystitis in women, 186
 Hip-joint, exsection of, 175
 ———, use of ligamentum teres of, 193
 Hirtz, phlegmonous periostitis, with ulcerative endocarditis, 257
 Hodge, death from use of sponge-tents, 139
 ———, extra-uterine pregnancy, 86
 Holman, chloride of iron in post-partum hemorrhage, 39
 Hooping-cough, treatment of, 209
 Hosch, serous cysts of iris, 260
- Hovey, rabies mephitica, 13
 Hugenberg, premature rupture of bag of waters, 225
 Humphry, treatment of wounds, 259
 Huppert, albuminuria and epilepsy, 108
 Hüter, subcutaneous injection of carbolic acid, 9
 Huttenbrenner, tetanus neonatorum treated by chloral, 166
 Hydatids, uterine, 134
 Hydrargyrum oleinicum, 58
 Hydrocele, total transparency in, 221
 Hydrocyanic acid, action of, 103
 ———, and atropia, antagonism of, 103
 Hygromata, containing false cartilages, treatment of, 272
 Hyperidrosis, hereditary local, 163
 ——— of feet, 163
 Hypospadias, 264
- Icthyosis linguæ, 170
 Iliac artery, ligature of, for fungus hæmatodes of sacro-iliac synchondrosis, 224
 Infants, alteration in weight of newborn, 45
 Insanity, chloro hydrate of morphia in, 253
 ———, phosphorus in, 62
 Intussusception, statistics of, 69
 Iodine, mode of action of, 53, 99
 Iodoform as a topical remedy, 8
 Ipecac enemata in bowel affections, 211
 ——— spray in bronchitic asthma, 255
 Iris, cystoid degeneration of, 169
 ———, serous cysts of, 260
 Iron, perchloride of, properties of, 104
- Jaccoud, connection of inflammation of heart with erysipelas of face, 158
 Jacobi, sarcoma of kidney in an infant, 166
 Jameson, double spleen and kidneys, 3
 Jaw, congenital malformations of lower, 193
 Jessop, amputation of upper extremity, 131
 Jürgensen, light forms of typhoid fever, 59
 Juvenin, urea in vomit, 5
- Kaczorowski, treatment of erysipelas, 27
 Katholitzky, arm and scapula wrenched off, 35
 Kaufmann, expulsion of uterine fibroid, 54
 Kelsey, perityphlitis, 263
 Kezmarozky, alteration in weight of newborn infants, 45
 Kidney, anatomy of, 97
 ———, granular contracted, in a child, 161
 ———, physiology of, 241
 ———, punctured wound of, 218
 ———, sarcoma of, in an infant, 166
 Kidneys, four, 3
 Kilpatrick, triple breasts, 51
 Klein, anatomy of serous membranes, 1
 Knee-joint, relation of extensor tendons to, 2
 Koch, changes produced in lung-tissue by irritants, 157
 Kohts, physiology of coughing, 99
 Kolbe, properties of salicylic acid, 246
 Krishaber, galvano-cautery in tracheotomy, 171
 Kroenlein, treatment of wounds, 73
 Kuester, action of modern bullets, 120
- Laborde, action of propylamine, 150

- Peltier, trimethylamine in acute rheumatism, 201
- Penis, amputation of, at pubes, 82
 ———— for epithelioma, 174
 ————, bone in, 50
 ————, congenital curvature of, 127
- Periostitis, phlegmonous, with ulcerative endocarditis, 257
- Peripleuritis, 209
- Peritoneum, anatomy of, 219
- Perityphlitis, 68, 263
- Perl, influence of anæmia on heart, 114
- Perls, intrauterine fibroma of orbit, 190
- Petit, disjunction of bones of face, 280
- Petiteau, iodoform as a topical remedy, 8
- Pflüger, herpes corneæ, 260
- Phenol, camphorated, 8
- Phosphorus, administration of free, 151
 ————, in insanity, 62
 ———— in melancholia, 206
- Phthisis, contagiousness of, 113
 ————, laryngeal, 207
 ————, lime phosphate and raw meat in, 113
- Phytolacca decandra in mastitis, 42
- Pichler, therapeutics of gall-stone colic, 161
- Pin, swallowing of a shawl, 172
- Pityriasis rubra, treatment of, 118
- Placenta, peculiar ring-shaped, low situation of, without hemorrhage, 275
 ———— prævia with fibroid of uterus, 39
- Pleura, on the liquid effused into, 211
 ————, sarcoma of, 65
- Pneumonia, carbolic acid in cheesy, 256
- Ponfick, blood in relapsing fever, 199
 ————, embolus causing aneurism, 14, 65
- Porta, radical cure of varix by chloral, 131
- Potassium bromide, action of, 6
- Pregnancy, lung affections during, 208
 ————, extra-uterine, 86, 277, 297
 ————, molar, 134
- Prompt, salivary fistula, 263
- Propylamine, action of, 150
- Pruritus urethræ and vaginæ, 90
- Pseudarthrosis irritant injections in, 35
- Puerperal diseases, prevention and treatment of, at Preston Retreat, 183, 229
- Putnam, reflex movements of non-paralyzed hand, 253
- Pyometra and Pyokolopos lateralis, 141
- Quaglino, potassium bromide in amblyopia, 212
- Quain, aneurism of radial artery, 84
- Quehl, action of apomorphia, 102
- Quinia as an abortifacient and oxytocic, 58
 ———— in infantile diseases, 152
- Rabies mephitica, 13
- Rapmund, quinia in infantile diseases, 152
- Ravicini, quinia in typhoid fever, 24
- Raymond, poisoning by osmic acid, 235
- Raynaud, pseudo-membranous enteritis, 211
- Rectum, cancer of, linear rectotomy in, 129
 ————, extirpation of lower end of, 83
- Réliquet, obstruction of ejaculatory duct, 265
- Resin-cloth, carbolized, 105
- Respiratory centre, 52
 ———— organs, peculiar affection of, 208
- Rest in treatment of diseases of chest, 22, 112
- Retinal arteries, pulsation of, in aortic disease, 260
- Revillout, vaginismus, 283
- Rheumatism, trimethylamine in acute, 201
- Rhinoplasty by a double flap, 213
- Richet, tolerance of heart to wounds, 126
- Rickety deformities of leg, treatment of, 182
- Riegel, action of alcohol on temperature, 11
- Rigidities, atropia in muscular, 248
- Ringer, ipecacuanha spray in asthma, 255
 ————, therapeutic value of sulphides, 195
- Robert, ailanthus glandulosa as a remedy for dysentery, 160
- Roberts, rest in chest affections, 112
- Robertson, repositio ciliorum for trichiasis, 170
- Roger, croup, 109
- Rokitansky, respiratory centre, 52
- Rose, resection as a remedy for abduction of great toe and bunion, 225
- Rosenstein, urine in Addison's disease, 202
- Rosenthal, death of muscle and apparent death, 4
- Ross, triple breasts, 51
- Rota, Cæsarean section, 38
- Roy, papaya juice, 57
- Rugge, ergotine in varicose veins, 88
- Sacro iliac synchondrosis, fungus hæmatodes of, 224
 ————, luxation of, 234
- Salicylic acid, antiseptic properties of, 246
- Saliva, saccharifying influence of infant's, 4
- Sattler, primary lupus of conjunctiva, 168
 ————, serous cysts of the iris, 260
- Savory, use of ligamentum teres, 193
- Sayre, exsection of hip-joint, 175
- Scapula and arm wrenched off, 35
- Schiffer, saccharifying influence of infant's saliva, 4
- Schlesinger, thermometry of the uterus, 85
- Schröder, treatment of cancer of uterus, 189
- Schwarz, urethro-rectal fistula following an abscess of prostate, 266
- Schwerin, poisoning by blistering collodion, 143
- Sebaceous tumours of scalp, 212
- Sée, iodine, 53, 99
- Sensibility, recurrent, 242
- Serous membranes, anatomy of, 1
- Sewell, passages of hair from bladder, 222
- Sewer traps, 47
- Skin disease, peculiar in children, 72
- Smallpox, infection of, 14
- Smith, death from sponge-tents, 139
 ————, phytolacca decandra in mastitis, 42
 ————, use of ether during labour, 37
- Soda, action of salts of, 55
- Sommerbrodt, laryngeal phthisis, 207
- Sores, hard, elastic threads in, 26
- Speir, aneurism of aorta treated by gallic acid and subsulphate of iron, 115
- Spiegelberg, exudation in neighbourhood of female genital tract, 90
 ————, primary carcinoma in body of uterus, 93
- Spina bifida cured by injection, 173, 272
- Spleen, double, 3
 ————, tumours of, in primary syphilis, 116
- Squarey, dysmenorrhœa, 44
- Strychnia, on the action of, 244

- Sulphides, therapeutic value of, 195
 Sweat, epileptic, 155
 Syphilis, tertiary, 106

 Tapeworm, remarks on eighty cases of, 118
 Tendon, luxation of tibialis posticus, 36
 ——— of triceps cruralis, rupture of, 133
 Tendons, relation of extensor, to knee-joint, 2
 Tents, death following use of sponge, 138
 Testicle, anatomy of, 145
 Testis, sarcoma of, 127
 Tetanus neonatorum, chloral in, 166
 ———, puerperal, 223
 Thiersch, properties of salicylic acid, 246
 Thompson, use of free phosphorus, 151
 Thumb, dislocation of, 179
 Thyroid body, structure of, 2
 Tibia, partial fracture of, in an adult, 224
 Tibial artery, anomalous course of, 223
 Tilt, lymphangitis in puerp pathology, 135
 Tinea tonsurans, treatment of, 120
 Toe, resection for abduction of great, 225
 Tommasi, carbolic acid in cheesy pneumonia, 256
 Tongue, amputation of, in a child, 29
 ———, extirpation of, after ligature of lingual artery, 214
 Torsion in amputation, 25
 Tracheocele, 216
 Tracheotomy, galvano-cautery in, 171
 Transfusion of lamb's blood, 11
 Traps, sewer, 47
 Trichiasis, new operation for, 261
 ———, repositio ciliorum for, 170
 Trimethylamine in acute rheumatism, 201
 Tripiet, recurrent sensibility, 242
 Tuberculization in children, 257
 Tumours, disquieting influence of pregnancy over pelvic abdominal, 281
 Twins at eighth month, 275
 Typhoid fever, fatty inunction in, 23
 ———, hypodermics of quinia in, 24
 ———, slighter forms of, 59
 Tyrrell, amputation of penis at pubes, 82
 ———, sarcoma testis, 129
 ———, sebaceous tumours of scalp, 212

 Uffelmann, peculiar infantile skin disease, 72
 Ulceration, tuberculous, of buttock, 267
 Ulcers, new method of curing, 167
 Umbilical cord, new method of tying, 42
 ———, prolapse of, 276
 Ungarelli, Cæsarean section, 36
 Urea in vomit, 5
 Urethra, vascular growths of, 89
 Urine, benzoic acid for ammoniacal, 70
 Uterine disease, treatment of, 137
 ——— soufflé after confinement, 280
 Uterus, absence of, 51
 ———, extirpation of inverted, 45
 ———, fibroids of, ergot in, 189
 ———, incision of cervix, 139
 ———, primary carcinoma of body of, 93
 ———, thermometry of, 85
 ———, treatment of cancer of, 189

 Vachell, morphia for hypodermic use, 12
 Vagina, bifid, impeding delivery, 276
 ———, congenital absence of, 44

 Vagina, rupture of, 136
 Vaginismus, 283
 Valenta, bifid vagina as an impediment to delivery, 276
 ———, bleeding to death of fœtus, 277
 ———, twins with a ring-shaped low situation of placenta without hemorrhage, 275
 Van Peyma, gunshot wound of brain, 27
 Varicose veins, injection of ergotine for, 88
 Varix of vena dorsalis penis treated by injection of chloral, 33
 ———, radical cure of, by chloral, 130
 Veiel, skin affections caused by bromide of potassium, 165
 ———, treatment of lupus erythematosus, 162
 Verneuil, bloodless extirpation of tumours of vulva, 284
 ———, extirpation of end of rectum, 83
 ———, linear rectotomy in cancer of rectum, 129
 Vertigo, auditory, 203, 248
 Vitreous, electricity in opacities of, 77
 Voisin, curative treatment of insanity by chlorhydrate of morphia, 253
 Volkmann, treatment of hygromata, 272
 Vomiting, on the act of, 147
 Vulva, bloodless removal of tumours of, 284

 Waldeyer, anatomy of retroperitoneal fossa, 219
 ———, retroperitoneal hernia, 218
 Wannebroucq, pseudo-membranous enteritis, 258
 Warlomont, new operation for entropion and tri-hiasis, 261
 Water, use of hot, in surgery, 134
 Watson, amputation of penis, 174
 ———, on the opening of the capsule before making the corneal section in operation for senile cataract, 122
 Watt, spina bifida cured by injection, 173
 Weber, anomalous face-presentations, 36
 ———, communicability of phthisis, 113
 Wecker, cystoid degeneration of iris, 169
 Weichselbaum, extirpation of tongue after ligature of lingual artery, 214
 Weil, tumours of spleen in primary syphilis, 116
 Weir, congenital curvature of penis, 127
 ———, paralysis caused by Esmarch's bloodless method, 76
 Weiske, effect of food on bones, 11
 Wernich, course of lung affections during pregnancy, 208
 Westphal, movements of extremities in hemiplegics, 251
 Willard, death from use of sponge-tents, 138
 Williams, bile in absorption of fats, 52
 ———, mucous membrane of uterus, 146
 ———, phosphorus in melancholia, 206
 Willigk, imperfectly healed Cæsarean section, 88
 Wilson, atropia in muscular rigidity, 248
 ———, death from use of sponge-tents, 139
 Wood, tests for blood, 95
 Wounds, treatment of, 73, 259

 Zuelzer, infection of smallpox, 14
 Zweifel, influence of inhalation of chloroform on fœtus, 89